Facet

Prior Authorization Appeal Form

Date:_____

A decision to not approve the originally requested specialty drug may be appealed using this form. This form must be completed by a physician and include all relevant information in support of the patient's appeal. The completion of this form does not guarantee a successful appeal. Any costs incurred by the completion of this form are the responsibility of the patient.

The rationale(s) cited in the decision to not approve the originally requested drug must be addressed within this appeal.

Please send the completed form to: appeals@facetprogram.ca or fax to: 1-844-446-1575

Patient Name:_____ **Date of Birth:**_____

Policy Number: _____ **Certificate Number:** _____

Reason for Appeal (please select all that apply):

- ☐ Confirmed allergy
- ☐ Contraindication
- ☐ Underlying medical condition has changed
- ☐ Randomized controlled trial (RCT) data

Description of Allergy, Contraindication or RCT Data:

*Please describe the nature of the intolerance or contraindication to the therapeutic alternatives for the originally requested medication.

*Please attach relevant lab results and clinical notes in support of the appeal, if applicable.

*If the appeal is based on RCT data, please attach a copy of the journal article and indicate the rationale here.

Please attach additional pages as needed.

_____	_____	_____
Physician Name	Physician Signature	Date