New Brunswick Drug Plans / Régimes de médicaments du Nouveau Brunswick
P.O. Box 690, Moncton, NB E1C 8M7
Toll Free Number: 1-800-332-3692
Toll Free Fax: 1-888-455-8322

Supporting Application Form
Other Drug Coverage

- If you have other drug coverage, this form must be submitted with your Application for Coverage for any of the New Brunswick Drug Plans. If your application includes a spouse and/or dependant(s), each family member who has other drug coverage is required to complete this form.
- Before you apply, contact the New Brunswick Drug Plans information line at 1-800-332-3692 to confirm that the drug you have been prescribed is included on the New Brunswick Drug Plans Formulary for the Plan for which you are applying. If a drug is listed as a special authorization benefit, your health care provider must submit a special authorization request before your application can be processed.
- The New Brunswick Drug Plans are a **payer of last resort, which means that you must use all other drug coverage options available to you before you are eligible**. This includes coverage through a private drug plan (including an appeal or exception process), a Health Spending Account (HSA) and a drug manufacturer's Patient Support Program.

Continuing Coverage

- If your application is approved, you must submit this form annually to confirm your continued eligibility. If your other drug coverage changes at any time, you must complete and submit a new Other Drug Coverage form along with the supporting documentation.

SECTION 1 - Applicant Information

First Name: _____ Last Name: _____

Medicare Number: |_|_|_| |_|_|_| |_|_|_|_| Date of Birth: |_|_| |_|_| |_|_|_|_| (D D M M Y Y Y Y)

SECTION 2 - Drug(s) Requested

Before you apply, contact the New Brunswick Drug Plans information line at 1-800-332-3692 to confirm that the drug(s) you are requesting is included on the New Brunswick Drug Plans Formulary for the Plan for which you are applying.

Drug Requested	**Strength**	**Drug Identification Number (DIN)** (if available)

SECTION 3 - Other Drug Coverage

Name of insurance companies or drug plans:

Health Spending Account Information

Do you have access to a Health Spending Account to cover the costs of your drugs? ○ Yes ○ No

If yes, have you reached the maximum covered under your Health Spending Account? ○ Yes ○ No

Date Health Spending Account balance renews: |_|_| |_|_| |_|_|_|_| (D D M M Y Y Y Y)

If you have a Health Spending Account, you must include proof of the amount of coverage remaining in your Health Spending Account at the time of your application to this plan.

SECTION 4 - Reason for applying

○ **My private plan requires that I apply to the New Brunswick Drug Plans before they will consider coverage**

The New Brunswick Drug Plans are a **payer of last resort, which means all other drug coverage options available to you must be explored and used before you can apply**. Coordination of benefits with other drug coverage is not permitted.

○ **I've been prescribed a drug that is not listed on my private plan formulary for the prescribed condition (indication)**

The New Brunswick Drug Plans will not consider requests for coverage because your private plan's reimbursement criteria are not met for the prescribed condition (indication).

You must include a letter from your private plan that confirms each drug you have been prescribed is not listed on the private plan formulary for the prescribed condition (indication). This letter must indicate that a request for exceptional coverage or appeal was declined. Plan booklets, general coverage information, or a printout from your private plan portal **will not** be accepted as proof.

○ **I've reached the maximum for drug coverage on my private plan**

Date drug maximum was reached: D D M M Y Y Y Y

Date drug maximum renews: D D M M Y Y Y Y

You must include a letter from your private plan that confirms you have reached the annual or lifetime drug maximum under the private plan. Plan booklets, general coverage information, or a printout from your private plan portal will not be accepted as proof.

SECTION 5 - Personal Declaration

By signing this form, I confirm the following:

I have pursued all other drug coverage options available to me, including coverage through a Health Spending Account, through an appeal or exception process under my private plan or a drug manufacturer's Patient Support Program.

I confirm that the information provided on this form is true to the best of my knowledge and I understand that knowingly providing false or incomplete information is an offence.

Name of Applicant: _____

X Sign here - Applicant:

Date signed: D D M M Y Y Y Y

This information is collected under the authority of the *Prescription and Catastrophic Drug Insurance Act and the Prescription Drug Payment Act*. This information will be used and disclosed to administer the New Brunswick Drug Plans. It may be used and disclosed in accordance with the *Personal Health Information Privacy and Access Act*, SNB 2009, c P-7.05. For more information regarding collection and use of personal information, visit www.gnb.ca/healthprivacy, or contact the New Brunswick Drug Plans at the address or telephone number shown on page 1 of this application.