Labourers' International Union of North America
Local 1059 Benefit Trust Fund

ADMINISTERED BY GLOBAL BENEFITS

191 The West Mall, Suite 901
Etobicoke, ON M9C 5K8
Tel 416-635-6000
Fax 416-635-6464

Medical Cannabis Prior Authorization Form

Plan Member Information – Complete the following sections (Please print)	
Plan Member:	Patient Name:
Plan Name: **LiUNA Local 1059 Benefit Trust**	Drug Card Number:
Patient Date of Birth (DD/MM/YYYY):	Preferred Phone Number:
Address (Number, Street, City, Province, Postal Code):	
May we contact you by email? (Note that some correspondence may still need to be sent by regular mail) ☐ Yes ☐ No	
If Yes, provide the email address:	
Do you have coverage of medical cannabis with another carrier? ☐ Yes ☐ No If yes, indicate information below: (DD/MM/YYYY)_____ coverage provide by:_____	

Treating Physician/Nurse Practitioner Information Section	
Name of Treating Physician/Nurse Practitioner	Specialty:
Address (Number, Street, City, Province, Postal Code)	
Telephone Number (including area code):	Fax Number (including area code):

1. Product Name: **Medical Cannabis**
2. Is your patient authorized to possess cannabis for medical purposes under current legislation? ☐ Yes ☐ No
3. Prescribed dosage form and regimen:_____
4. Diagnosis/Indication for use (include date of initial diagnosis) (MM/YYYY):_____
   - ☐ Neuropathic/ Chronic Pain ☐ Spasticity ☐ Palliative Care ☐ Anorexia
   - ☐ Spinal Cord Injury ☐ Anorexia ☐ Nausea/vomiting from chemotherapy treatment
5. What is the anticipated duration of treatment with medical cannabis? _____

I certify that the information provided is true, correct and complete.

Treating Physician/Nurse Practitioner Name	Treating Physician/Nurse Practitioner Signature
Date	License Number

It is important to provide the requested information in detail to help avoid delay in assessing claims for Medical Cannabis. The completed form can be returned to LiUNA Local 1059 Global Benefits by mail, fax or email.
Note: As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

Email: benefits@globalben.com