International Brotherhood of Electrical Workers Local 353

Medical Cannabis Coverage: Frequently Asked Questions

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CUBIC

Prior Authorization for Medical Cannabis Coverage

How do I access medical cannabis coverage under IBEW Local 353's benefit plan?

Claims for medical cannabis are managed through the same Prior Authorization process as other specialty therapies. To initiate the process, a Physician must provide a valid Medical Document authorizing the use of medical cannabis and complete the medical cannabis Prior Authorization form. This form outlines the clinical need for medical cannabis and its intended use. The request is then reviewed by the FACET Program and a coverage decision is rendered.

What is the FACET Program?

FACET is an independent, third-party Prior Authorization program for specialty therapies administered by a team of Clinical Pharmacists who evaluate claims based on established evidence-based clinical criteria. FACET operates independently of the cannabis and pharmaceutical industries to ensure objective assessments.

What medical conditions are eligible for medical cannabis coverage?

FACET considers medical cannabis coverage for the following medical conditions ONLY:

1) **Chronic Neuropathic (Nerve) Pain**
2) **Spasticity secondary to Multiple Sclerosis or Spinal Cord Injury**
3) **Chemotherapy Induced Nausea and Vomiting**
4) **Pain in a Palliative Care Setting (most commonly associated with late-stage cancer)**
5) **Pediatric Treatment Resistant Epilepsy**

FACET regularly reviews the list of eligible medical conditions as new medical evidence and clinical practice guidelines become available that support use of medical cannabis. **Coverage is only approved if a patient has failed adequate trials of appropriate first-line therapies.**

How did FACET determine the list of eligible medical conditions?

While medical cannabis is used for various conditions, most benefits remain anecdotal, lacking controlled clinical studies. The eligible conditions listed above have the highest level of evidence that supports the safe and effective use of medical cannabis in that condition.

What does the term "first-line" therapy mean?

A first-line therapy refers to a medication (or class of medications) that has evidence supporting its use as being the most appropriate initial therapy for a given medical condition. For example, in chronic nerve pain, pregabalin (Lyrica®) is considered a first-line medication (along with other medications from other classes). Medical cannabis is not an approved first-line therapy for any medical condition and is only considered when first-line treatments have failed.

Are there any financial limits to the coverage if approved?

If approved through the FACET Program, medical cannabis coverage is limited to a maximum of $1,000 per person per year.

Do I have to use a specific Licensed Producer/Seller if my Prior Authorization request is approved?

IBEW Local 353 has chosen to partner with **Starseed Medicinal,** a Canadian Licensed Producer with experience working with other trade unions, to provide evidence-based medical cannabis products and optimal patient care. If approved for coverage through FACET, plan members must receive their medical cannabis products through Starseed Medicinal to have their products reimbursed under the benefit plan. Approved claims are submitted electronically by Starseed to Canada Life.

If my Prior Authorization request is approved, how long is coverage valid for?

If coverage is approved, the Prior Authorization decision letter you receive from FACET will indicate how long your coverage is valid for, with that duration depending on the underlying clinical characteristics of the claim. The maximum approval period under the plan is 12 months at which point a member must fill out a renewal form for coverage through FACET.

If my Prior Authorization request for coverage is denied, does that mean I cannot use medical cannabis?

No, a denial does not prevent a member from using medical cannabis. A completed and valid Medical Document for medical cannabis entitles any member to access medical cannabis independently. The Prior Authorization process determines only whether coverage is available under IBEW Local 353's benefits plan for that member.

If I have already been using medical cannabis prior to now, do I still need to go through this Prior Authorization process to be eligible to claim medical cannabis under the FACET Program?

Yes. Prior or current use of medical cannabis does not guarantee coverage. Members must meet established clinical criteria before coverage is approved.

Can I (or my Physician) appeal a medical cannabis Prior Authorization decision?

Yes. Appeals will be permitted under the following circumstances:

- Important clinical information was omitted from the initial submission
- There has been a material change in the patient's condition and/or treatment history, supported with appropriate clinical evidence.

How do I start the process of applying for medical cannabis coverage?

There are two ways in which the process can be initiated:

1. **Through a Physician:** If your medical cannabis is being authorized by your family physician or specialist, they will need to fill out the medical cannabis Prior Authorization form and submit it to the FACET Program. FACET will send a letter to you and your physician outlining the coverage decision and clinical rationale. If approved, you will be referred to Starseed Medicinal to register and place your first order for medical cannabis.
2. **Through Starseed Medicinal:** Members can contact Starseed Medicinal directly (https://www.starseed.com/register) to schedule an initial appointment with an affiliated Nurse Practitioner or Physician to determine if medical cannabis is a suitable treatment option and submit a Prior Authorization form to FACET to determine coverage eligibility.

NOTE: Working with a Starseed-affiliated healthcare provider does not guarantee coverage. FACET's approval is based on strict clinical criteria, and requests outside of these criteria will not be approved.

Where do I access the FACET Prior Authorization form for medical cannabis?

The FACET Prior Authorization form for medical cannabis can be accessed through the following:

- **TEIBAS.com, or myTEIBAS.com**
- **Starseed Medicinal (https://www.starseed.com/register or 1-844-756-7333)**
- **By contacting the FACET program directly:**

  Website: www.facetprogram.ca
  Email: claims@facetprogram.ca
  Phone: 1 (844) 492-9105
  Fax: 1 (844) 446-1575

Prior Authorization Request Form: Medical Cannabis

Plan Member/Patient: Please complete pages 1-2 and then take the form to your physician/practitioner for completion. Completion of this form is not a guarantee of approval. All costs incurred to complete this form are the plan member's responsibility.

PART 1: PATIENT INFORMATION

Patient Name:	**Plan Member** Name:
Patient Date of Birth (YYYY/MM/DD):	**Plan Member** Date of Birth (YYYY/MM/DD):
Patient's Sex: ☐ Male ☐ Female ☐ Other / Prefer not to disclose	
Plan Sponsor/Employer:	Plan Group/Contract Number: / Certificate/ID Number:
If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: ☐ Spouse ☐ Dependant	
Patient Email: _____ *Note: A valid email address is **required** to receive renewal reminders when the approval period is near term. Phone number is for clarification or request for additional information only.*	Patient Phone Number: _____ Preferred language of communication: ☐ English ☐ French
Patient Address: _____ (Number) _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)	
Preferred method of communication with FACET about any and all claim(s), including prior and subsequent claim(s). If you select email, you agree and accept that email may contain medical information, and that the security of email can never fully be guaranteed: ☐ Email ☐ Mail	

PART 2: CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

As of the date hereof, I hereby authorize any person or organization who has personal health information about me, including any health care professional (which includes but is not limited to physicians, medical specialists, physiotherapists, pharmacists or any other person who has examined or treated me), health care institution, pharmacy patient support program, and other medical-related facility, and any authorized agent of mine to release and disclose to Cubic Health Inc. ("Cubic"), the company that runs the FACET Program, any personal information regarding my past medical history and current medical condition, including any relevant clinical notes (collectively, the "Personal Health Information"), which may be required to adjudicate the Request for Prior Authorization to which this Consent forms a part (the "Request").

I understand and agree that Cubic will keep any Personal Health Information obtained from such persons, organizations and/or agents secure and confidential and in accordance with applicable legislation and that my Personal Health Information will not be shared with any other party with the exception of the insurance carrier for adjudication or processing of prescription claims, and the plan's designated pharmacy/pharmacy network for dispensing/distribution when required, and the relevant Patient Support Program to facilitate medication access, when required.

I authorize Cubic to collect, use and maintain my personal information, such as name, address, email address, and the Personal Health Information it deems necessary, for the purposes of adjudicating the Request or any purposes in any way ancillary thereto.

I authorize Cubic to collect, use and disclose my personal information in accordance with its Privacy Policy located at: https://www.facetprogram.ca/en/privacy/.

I hereby acknowledge and understand that:

- access to and disclosure of my Personal Information will be limited to Cubic pharmacists and other Cubic employees in the course of their employment with Cubic, the insurance carrier, the plan's designated pharmacy/pharmacy network (if applicable), and the Patient Support Program (if applicable);
- any cost(s) associated with the completion of this form is my responsibility to pay;
- by filling out the Request, I am not guaranteed approval for any level of coverage;
- Cubic is an independent clinical review panel and is not affiliated with my employer, plan sponsor, plan administrator or insurance company and that Cubic has been engaged for the purpose of ensuring that criteria for the approval of claims are satisfied before approval is granted, and to ensure that the criteria for coverage are implemented consistently;
- Cubic specifically assumes no responsibility for the completeness or accuracy of any Personal Information which may be provided to Cubic in connection with the Request, and Cubic disclaims all liability for any loss or damage suffered by any person, including (without limitation) me, as a result of the processing or outcome of the Request;
- I have no claim against Cubic for any loss or damage (direct, indirect, incidental, consequential or otherwise) I may suffer as a result of the handling, processing or outcome of the Request.

I understand and agree to the terms above. *(If the patient is a minor, a parent/guardian must sign below. For the purposes of this consent form, a minor is anyone under the legal age of majority in their province or territory of residence).*

_____	_____	_____
Patient Full Name (please print)	Patient Signature	Date Signed (YYYY/MM/DD)

PART 3: COORDINATION OF BENEFITS

Is the **patient** currently on (or has previously been on) this medication? ☐ Yes ☐ No

If yes, medication start date (YYYY/MM/DD): _____ Coverage has been provided by: _____

If established on therapy, attach documentation of prior coverage (e.g. history of claims from pharmacy records demonstrating previous use and coverage) (required)

Is the patient covered under another health benefits company or prescription drug insurance plan? ☐ Yes ☐ No

If yes, please indicate if the patient has applied for coverage or received any financial support for this medication from any of the ***following***:

PRIVATE PLAN

Has the patient applied for coverage under another private insurance plan? ☐ Yes ☐ No

If yes, name of insurance company: _____ Policy/Plan Number: _____ Certificate Number: _____

Plan holder's name: _____ Plan holder's date of birth: _____ Patient's relationship to plan holder: ☐ Self ☐ Spouse ☐ Dependant

Coverage decision under the private plan: ☐ Approved ☐ Denied ☐ Pending ☐ Not Submitted

Provide details including coinsurance and any applicable maximums: _____

Please attach documentation of acceptance or declination

PROVINCIAL PLAN

Has the patient applied for coverage under a provincial program? ☐ Yes ☐ No

If yes, name of provincial program(s): _____

Coverage decision under the provincial plan: ☐ Approved ☐ Denied ☐ Pending ☐ Not Submitted

Please attach documentation of acceptance or declination.

PATIENT SUPPORT PROGRAM

Is the patient enrolled in any patient assistance/compassionate care program(s)? ☐ Yes ☐ No

If yes, name of Patient Assistance Program(s): _____ Patient Program ID Number: _____

Patient Assistance Program Contact Name: _____

Email: _____ Telephone: _____ Fax: _____

Please note, obtaining a compassionate (bridge) dose without prior authorization approval does not secure coverage.

PART 4: CURRENT/PAST PHARMACY INFORMATION

Please provide contact details of the pharmacy/pharmacies from which the patient has received medications over the last two years.

Pharmacy Name	Location (Street and City)	Phone Number

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Prior Authorization Request Form: Medical Cannabis

Prescribing Practitioner: Please provide information on your patient's medical condition/drug history.

PART 1: PRESCRIBER INFORMATION	
Practitioner Name:	
Speciality:	Registration Number:
Address:	
Fax Number: (_____)_____ *(required)*	Phone Number: (_____)_____

PART 2: CLINICAL INFORMATION	
For all medical cannabis requests, please complete the following:	
Date of initial diagnosis (YYYY/MM): _____	Anticipated duration of treatment *(Max approval is 1 year)*: _____
Patient's current weight (required): _____ kg or _____lbs	Does patient have any relevant drug allergies? ☐ Yes ☐ No Nature of allergy, if applicable: _____
Current CAGE-AID score (1-4): _____ Date (DD/MM/YYYY): _____	Has the Medical Cannabis Authorization Document been completed for your patient? ☐ Yes ☐ No **If yes, please attach a copy of the Medical Cannabis Authorization Document.**

Please select the patient's diagnosis below and provide the relevant clinical information:

☐ CHRONIC NEUROPATHIC (NERVE) PAIN / PAIN IN PALLIATIVE CARE SETTING

☐ Chronic Neuropathic (Nerve) Pain ☐ Pain in Palliative Care Setting ☐ Other: _____	Has the patient experienced refractory pain despite standard first-line treatments? ☐ Yes ☐ No

Please provide the results of at least **one** of the following clinical assessments as applicable:

Baseline Visual Analogue Scale Pain Score (1-100): _____ Date (DD/MM/YYYY): _____	Baseline Numerical Rating Scale Pain Score (0-10): _____ Date (DD/MM/YYYY): _____	Alternatively, please provide the results of a suitable clinical assessment tool (BPI, McGill Pain Questionnaire, Quality of Life Assessment, SF36 etc.) Clinical Assessment Tool: _____ Summary of Results: _____

Please provide any additional information that supports the use of medical cannabis for this patient:

☐ CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING (CINV)

Cancer diagnosis and stage of disease: _____	ECOG performance status: _____	Concurrent antiemetic therapy to be used with medical cannabis: _____
Current chemotherapy regimen: _____ Date started (DD/MM/YYYY): _____ Number of cycles remaining: _____	Has the patient previously failed or experienced inadequate control with standard antiemetic treatments? ☐ Yes ☐ No	

Please provide any additional information that supports the use of medical cannabis for this patient (severity/frequency of nausea/vomiting):

☐ PEDIATRIC TREATMENT-RESISTANT EPILEPSY

Current Seizure Frequency: ☐ Daily: ____ seizures Date (DD/MM/YYYY): ☐ Weekly: ____ seizures _____ ☐ Monthly: ____ seizures	Is there evidence of treatment resistance (failure of ≥2 anti-seizure medications?) ☐ Yes ☐ No If no, explain why medical cannabis is being considered: _____
Age at Epilepsy Onset: ____	Has the patient previously used any form of cannabis-based therapy? ☐ Yes - if yes, please specify: _____ ☐ No

☐ SPASTICITY IN PATIENTS WITH MULTIPLE SCLEROSIS OR SPINAL CORD INJURY		
Diagnosis: ☐ Relapsing-remitting multiple sclerosis ☐ Secondary-progressive multiple sclerosis ☐ Other (please state):_____		
Date of Initial Diagnosis (MM/YYYY): _____	Indication(s) For Use (Spasticity/Pain): _____	Date of Onset of Spasticity Symptoms (MM/YYYY): _____
Please provide the results of at least **one** of the following clinical assessments as applicable:		
Clinician-Rated Modified Ashworth Score: _____ Date (DD/MM/YYYY): _____	Patient's Spasticity Numerical Rating Scale Score (0-10): _____ Date (DD/MM/YYYY): _____	Patient's Current Expanded Disability Score (EDSS): _____ Date (DD/MM/YYYY): _____

PART 3: RELEVANT CURRENT/PREVIOUS THERAPIES

Medication Name	Dose	Start Date (MM/YYYY)	End Date (MM/YYYY)	Outcome *(Please provide details of intolerance, therapeutic failure, or contraindication)*

PART 4: RELEVANT CURRENT/PREVIOUS COMORBIDITIES

Is the patient diagnosed with any of the following medical conditions and/or has a strong family history of these conditions?

Medical Condition	Date of Diagnosis (YYYY/MM/DD)	Description of Current Condition/Severity (if applicable)
Schizophrenia: ☐ Yes ☐ No		
Substance Use Disorder: ☐ Yes ☐ No		
Respiratory Condition: ☐ Yes ☐ No		
Cardiac Condition: ☐ Yes ☐ No		

Please confirm if the patient is currently: Pregnant: ☐ Yes ☐ No Breastfeeding: ☐ Yes ☐ No

PART 5: RENEWAL REQUEST

Date patient started medical cannabis (MM/YYYY): _____

Overall clinical impression of benefit (please provide details of any follow-up assessments completed to measure efficacy and safety):

PART 6: ADDITIONAL INFORMATION

Please attach all relevant clinical information to support medical necessity of medical cannabis, including any contraindications to relevant medications, along with a copy of the Medical Cannabis Authorizing Document.

Please be advised further information may be requested if needed to facilitate determination of coverage.

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

_____ _____

Prescribing Practitioner's Signature Date Signed (YYYY/MM/DD)