FACET Prior Authorization Program

Program Overview & FAQs

CUBIC

1. FACET Program Overview

What is FACET?

The FACET Program (FACET) is an independent, third-party administered Prior Authorization program for specialty drugs used to treat complex conditions. FACET was launched in 2015 in response to increasingly complicated Prior Authorization cases and requests to assist both plans and plan members. FACET is a concierge service for members that provides independent expert assessment, quicker turnaround, and helps to ensure the most appropriate medication is being used in every case.

The FACET Program's philosophy is ensuring the right medication, at the right dose, at the right time for a member dealing with a complex condition using a member-centric, transparent and evidence-based approach.

In 2024, over 90% of FACET reviews were completed the same day and 99% within 2 business days, after all required clinical information was received.

Who administers FACET?

FACET is administered by Cubic Health (Cubic) and its team of licensed, independent, Clinical Pharmacists. Cubic has been involved in the management of health benefit plans in Canada since 2003 and currently manages Prior Authorization for over 1 million Canadians. Cubic has reviewed over 60,000 Prior Authorization cases across more than 200 disease states. The FACET Clinical Team members are experts in the pharmacological management of these complex conditions.

One of FACET's Clinical Pharmacists manages every FACET case from beginning to end. The plan member experience is built around direct access to the Clinical Pharmacist and a collaborative approach with the prescribing physician to ensure the best treatment. FACET Pharmacists interact directly with prescribers: the plan member is not the communication conduit between the plan member and the physician. Moreover, members have direct access to a Clinical Pharmacist Case Manager who will manage their claim from start to finish.

FACET renders an unbiased assessment based on the clinical information provided, using the most up-to-date clinical evidence available at the time of the request. Decisions and rationales are delivered to members, physicians, and Patient Support Programs (if applicable).

FACET and Cubic have no financial stake in the outcome of any case and are completely independent of all industry stakeholders, including insurance carriers, claims processors, and pharmaceutical manufacturers. FACET is a fee-for-service program, which means there is no incentive to approve, deny, or alter a medication request.

What is "Disease State-Based" Prior Authorization?

Most Prior Authorization programs use a *drug-based* approach – meaning that a physician must fill out a specific form for a specific drug they are looking to prescribe. FACET is different – the focus is on the *disease state*, not the drug. Members and their physician complete a Prior Authorization form that relates to the condition being treated, not the drug being requested.

Detailed information about the underlying disease state is needed to determine the most appropriate therapy for a plan member based on the clinical features of the underlying condition and past drug therapy. Examining a plan member's disease state characteristics and their past drug therapy in detail requires a clinical approach, which is why all FACET cases are reviewed start to finish by a licensed, Clinical Pharmacist with expertise in the disease state being treated.

How is a clinical decision rendered by FACET?

The FACET Clinical Team answers the following three (3) key questions for each request:

1) Does a plan member qualify for any specialty drug for a given underlying condition? *If so*:
2) What is the most appropriate (i.e. from an effectiveness, cost-effectiveness and safety perspective, supported by up-to-date clinical evidence) therapy in this case?
3) What is the most appropriate dosing regimen for the drug selected?

FACET relies on the most current evidence-based criteria from an array of clinical resources to render decisions, including from Health Canada and Canada's Drug Agency (CDA). All decisions and rationales are transparently disclosed to plan members and their physician.

What disease states and medications are covered by FACET Prior Authorization?

FACET focuses primarily on specialty drug therapy, which is generally defined as drug therapy with an annual cost of at least $5,000 where there is a significant opportunity for pharmacist intervention.

There are dozens of disease states requiring specialty drug therapy that are included under the FACET Program. Some of more common disease states that FACET encounters include:

- Asthma/COPD
- Cancer
- Chronic Migraine Headaches
- Crohn's Disease/Ulcerative Colitis
- Hypercholesterolemia (high cholesterol)
- Multiple Sclerosis
- Psoriasis
- Rheumatoid Arthritis

2. Prior Authorization – Purpose and Philosophy

Why is the IBEW Local 353 using Prior Authorization?

The cost of prescription medications in Canada has risen dramatically in recent years, with some specialty drugs now exceeding $1 million per year. Many of these therapies are intended for complex or rare conditions and are prescribed only when certain clinical criteria are met, such as a specific level of disease severity or failure/intolerance of traditional treatments.

By implementing a Prior Authorization program like FACET, IBEW Local 353 is helping ensure that these high-cost medications are used appropriately, safely, and in accordance with the latest clinical evidence.

Prior Authorization helps protect members by ensuring that treatment decisions are based on sound medical evidence, while also protecting the long-term sustainability of the benefits plan. This approach ensures that plan dollars are being used responsibly, and that all members have fair and consistent access to the most appropriate therapy for their condition.

Why do I have to get Prior Authorization for a drug that I need, which my physician has prescribed?

We understand that it can be frustrating to face additional steps when your physician has already prescribed a medication. However, in many complex disease states, there are often multiple treatment options available, including some that are equally effective, safer, or significantly more cost-effective.

Physicians are experts in diagnosing and managing disease but may not always have access to up-to-date information on comparative drug pricing or the most current real-world evidence across all treatment options. FACET is not questioning your physician's clinical judgment but rather providing a second layer of expert review to confirm that the prescribed medication meets evidence-based criteria and is the most appropriate option for your situation.

The goal of Prior Authorization through FACET is not to deny access to care but to ensure that plan members receive the most effective treatment at the right time and that the benefits plan remains sustainable for everyone. FACET Clinical Pharmacists work collaboratively with your physician to ensure that the final treatment decision is based on a full understanding of both your clinical needs and the available therapeutic options.

Why is FACET approving me for another drug instead of the one my physician prescribed for me? What do I do now?

In many cases, there is more than one treatment option available for a given condition. FACET decisions are based on a comprehensive review of the latest clinical evidence, safety data, and cost-effectiveness. If an alternative medication is recommended, it is because the FACET Clinical Pharmacist has determined that the alternative is equally effective and safe, but offers better overall value to the benefits plan.

This does not mean the medication your physician prescribed is inappropriate. However, in situations where multiple therapies are clinically comparable, FACET will recommend the option that provides the best outcome for both the member and the plan. This helps ensure fairness and consistency across all plan members and supports the sustainability of the plan for the long term.

FACET communicates directly with your physician and provides a clear clinical rationale for any alternative recommendation. If your physician agrees that the alternative medication is appropriate, they can indicate their selection to the FACET Clinical Team and issue a new prescription for the alternative therapy. Once that confirmation is received, FACET will finalize the approval and notify you when the medication is ready to be dispensed through your pharmacy.

If your physician does not believe the alternative is clinically appropriate for your specific situation, they can provide additional medical information to FACET for further review and reconsideration.

If my request is not approved as submitted, does that mean my physician is prescribing the wrong medication? Why would a third-party team of pharmacists know better than my own physician what medication I should be taking?

FACET is never suggesting a physician is prescribing inappropriately. Rather, FACET aims to serve as a collaborative resource, working alongside prescribers to support access to medications based on established coverage criteria and benefit plan requirements. The challenge for any physician is that in complex disease states there are often many therapeutic options to choose from. It is difficult to keep track of the latest evidence base, such as comparative effectiveness and differences in pricing. The FACET team of Clinical Pharmacists are independent medication experts in these areas. There are over a dozen Clinical Pharmacists with advanced training reviewing cases and the underlying evidence base used to render decisions. FACET has reviewed over 60,000 requests to date.

In many cases, there are multiple options that can be considered for therapy. When a physician prescribes a medication, that does not necessarily mean the prescribed medication is the only valid and appropriate option available for a given patient. It may simply have been the first option chosen among various alternatives.

With new medications entering the market every month in Canada, the underlying primary medical evidence is constantly changing. In such a dynamic area, FACET is an independent resource to help assess and recommend the most clinically effective and cost-effective therapies wherever possible.

My specialist recommended I try another drug for my cancer treatment, but FACET has denied it. Why would FACET deny a cancer drug?

We understand that a cancer diagnosis is incredibly difficult, and the last thing any member wants to hear is that a recommended treatment is not covered. FACET reviews every cancer drug request based on the most current clinical evidence, expert guidelines, and cost-effectiveness assessments.

In Canada, independent health technology assessment (HTA) agencies such as Canada's Drug Agency (CDA) and the Institut national d'excellence en santé et en services sociaux (INESSS) evaluate new cancer drugs and make recommendations on whether they should be funded based on clinical benefit and cost-effectiveness. FACET relies on these assessments, along with other clinical resources, to determine whether a drug provides meaningful benefit relative to its cost.

Unfortunately, not all cancer drugs meet these criteria. Some treatments may be extremely expensive but offer limited or uncertain benefit when compared to existing alternatives. In such cases, FACET may determine that the requested drug does not meet the plan's coverage criteria.

If your request is denied, you may be contacted by a Medication Access Coordinator who will explain the decision and help you explore alternative coverage options, such as public programs, manufacturer support, or clinical trials. FACET also works directly with your specialist to ensure that any available alternatives are reviewed and discussed.

3. Submitting a Request

What is the process for submitting a FACET request?

The process for submitting a FACET request is straightforward and very similar to existing Prior Authorization submission practices:

- Both the plan member and the physician have access to FACET disease state forms. FACET Prior Authorization forms can be found online at www.facetprogram.ca. They can be completed and submitted online or faxed to FACET (along with all supporting clinical information). The insurance carrier, Canada Life, will also redirect plan members to FACET.
- The plan member is required to provide consent to Cubic and the FACET Program to contact the physician(s) and any pharmacy/pharmacies the member may be using to obtain additional information relevant to the case.
- Once received, the FACET Clinical Team can review the information and render a decision.
- If the decision is made to approve a medication, the information is shared with Canada Life to ensure the member can claim through the plan.

How do I access the Drug Prior Authorization Program?

In most cases, your treating physician, and in some situations, your pharmacist or a Patient Support Program, will already be aware if the medication you require needs Prior Authorization. If Prior Authorization is required, follow the steps below:

1) Visit https://www.facetprogram.ca/en/
2) Click "Find my form"
3) Search for the name of your medication
4) You will have the option to either print the form immediately or have it emailed to your personal email address
5) Bring the form to your treating physician for completion
6) Once completed and signed, the form should be submitted directly to FACET by:

   Fax: 1-844-446-1575

   Email: claims@facetprogram.ca

How do I look up if a drug is covered under our benefit plan or if the drug requires Prior Authorization?

If you are unsure whether a medication is covered or requires Prior Authorization, you can use the Drug Search Tool in your My Canada Life at Work profile to look up the medication by name. This tool will indicate whether the drug is covered by the IBEW Local 353 benefit plan and whether Prior Authorization is required.

To use the Drug Search Tool:

1) Log in to your Canada Life profile at https://my.canadalife.com/sign-in/
2) Click on “Benefits”
3) Click "Coverage and Balances"

4) Select "Health, Drugs, Vision & Dental"
5) Select "Drugs"
6) Click "Drug Search"
7) Type in the name of the medication you wish to search

Does the IBEW Benefit Plan reimburse for fees charged by my physician to complete the Prior Authorization form?

The IBEW Local 353 Benefit Plan reimburses for fees charged by physicians to complete prior authorization forms under the FACET program. There is calendar year maximum of $300 per insured for this benefit. For active members the $300 maximum also includes completion of certificates of disability. You can submit the fee for reimbursement online at my.canadalife.com/sign-in.

4. Decisions and Approvals

What decisions are possible with a FACET request?

There are three (3) possible decisions that can be rendered in the FACET Program:

1) Request is Approved as submitted.
2) Request is Conditionally Approved – a decision has been made to approve specialty therapy for the member, but the medication and/or dosage regimen prescribed must be optimized in order for the request to be approved and reimbursed by the plan (i.e. there is a more cost-effective, safe and evidence-based therapy available and/or there is a change needed to the requested dose of a medication.) A *Conditional Approval* happens most commonly in cases where multiple therapies exist, and some may be substantially more expensive than others but are not any more effective or safe.
3) Request Does Not Meet Criteria – case where either a member does not meet evidence-based clinical criteria for any specialty medication for a given disease state, or where a medication does not meet established cost-effectiveness thresholds. For example, there are medications on the market today that are not covered by some plans because the proven clinical benefit of the therapy is minimal and does not justify the cost of the medication.

How long does it take to get my Prior Authorization outcome from FACET?

Once all required clinical information has been received, 99% of FACET Prior Authorization requests are reviewed and completed within 2 business days or less.

If information is missing when the Prior Authorization form is submitted, the FACET Clinical Team will reach out to your physician, clinic, or Patient Support Program to request the missing details. The overall turnaround time then depends on how quickly that information is provided. You may also be contacted directly if additional consent or clarification is needed.

As soon as all necessary information is received, FACET will complete the review and render a clinical decision within 2 business days. If your request is approved, FACET will notify Canada Life to activate the approval in

their system so that you can begin claiming the medication. This final step may take 1-3 additional days, depending on the volume of requests being processed with the insurance carrier.

How long is a Prior Authorization approval valid for?

Most Prior Authorization approvals for chronic therapies are valid for up to 1 year. After that time, a renewal request must be submitted using a Prior Authorization form available on the FACET website.

Renewals are required to ensure that the medication is continuing to work as intended and remains the most appropriate option for your condition. If the treatment is no longer effective or there are ongoing concerns, FACET may recommend alternative therapies for you and your physician to consider.

This renewal process helps ensure that members continue to receive the safest, most effective care based on how their condition is responding over time.

I was approved for Ozempic®, and I thought I didn't have to get annual approvals, but when I went to the pharmacy, my refill was denied. Why did that happen?

Ozempic®, other GLP-1 medications used to treat diabetes (such as Mounjaro® and Rybelsus®), and most specialty medications are typically approved with specific dose limits. For example, you may have been approved for Ozempic® to a maximum of 1 mg per week. **If your prescriber increases your dose beyond the originally approved amount, a new Prior Authorization form must be submitted to FACET.**

This step ensures that the dose increase is medically necessary and that your diabetes is not adequately controlled at the lower dose. It also allows FACET to confirm that the higher dose is being used to manage diabetes specifically, and not for any off-label or investigational use.

Due to growing concerns about the inappropriate use of GLP-1 medications for unapproved indications, IBEW Local 353 requires re-evaluation when a higher dose is prescribed. This helps ensure responsible use of plan resources while continuing to support members with legitimate medical need.

5. Appeals and Privacy

Can I appeal a FACET decision?

Yes - it is possible to appeal a FACET decision provided one or more of the following criteria are met:

1) The underlying disease state has changed materially since the initial FACET decision was rendered and a subsequent review of the case is warranted.
2) There are documented and justifiable clinical reasons why specified alternatives are not options for you.
3) There has been a material change to the published medical evidence that warrants a review.

Appeals are not considered for products that are defined exclusions from under the IBEW Local 353 benefits plan. To determine whether a medication is excluded, please refer to your benefits booklet or use the Canada

Life online drug look up tool. This tool indicates whether the drug is covered by the IBEW Local 353 benefit plan and whether Prior Authorization is required.

To use the Drug Search Tool:

1) Log in to your Canada Life profile at https://my.canadalife.com/sign-in/

2) Click on "Benefits"

3) Click "Coverage and Balances"

4) Select "Health, Drugs, Vision & Dental"

5) Select "Drugs"

6) Click "Drug Search"

7) Type in the name of the medication you wish to search

Moreover, it is important to note that individuals who are, for whatever reason, not approved for speciality drug therapy have access to a Medication Access Coordinator ("MAC"). The MAC is a reimbursement navigation specialist who assists when a medication request cannot be approved by the plan and can help explore alternative reimbursement options, such as provincial funding, manufacturer assistance programs, or clinical trials. If applicable, the MAC assists members with the appeal process.

If you would like to speak with a MAC following a conditional approval or denial, please contact the MAC team at mac@facetprogram.ca , and they will arrange a follow-up where applicable.

Is my confidential medical information shared with the union?

No - under no circumstance does FACET share any confidential details of a case with IBEW Local 353. The only individuals that have access to FACET case information are you, the FACET Clinical Pharmacist, the Insurance Carrier, your physician(s), your pharmacy, and the Patient Support Program (where involved).

6. Contact Information

How do I contact the FACET Program?

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

7. Biosimilar Switching Overview

Like many other provincial and private drug plans, the trustees of the IBEW Local 353 Benefits Plan made the decision to transition to the use of biosimilar drugs on January 1, 2024.

This means that as new biosimilars come to market Plan members and their dependants who are currently taking an originator biologic drug must switch to a biosimilar version to maintain coverage. This change is made based on industry standards and best practices, but most importantly, so that the Plan can continue to provide important medication coverage for all Plan members well into the future. For over 15 years, biosimilars have been used in the European Union, and Ontario is the eighth province to expand the use of biosimilar medications.

What is a biosimilar drug?

A biosimilar drug, or biosimilar, is a medicine that is very close in structure, function, safety, and efficacy to an existing biologic drug (also known as the originator or reference drug). Once the patent of an originator drug expires, other manufacturers may produce biosimilars. Health Canada authorizes biosimilars for sale using the same strict standards for quality, effectiveness and safety as for all other biologic drugs. In some cases, biosimilar drugs can cost up to 50% less than the originator biologic drug.

An increasing number of biosimilar drugs will be entering the market in the coming years. It is important for patients to learn about this type of drug so that they can participate actively in discussions about biologics and biosimilars with their doctor and be aware of their treatment options.

What is an originator (or reference) biologic?

The first version of a biologic drug produced is called the "originator" or "reference" biologic drug.

Are biosimilar drugs as effective as originator biologic drugs?

Health Canada monitors the safety of all drugs on the market, including biosimilars. Biosimilars are only approved for sale after demonstrating that there are no meaningful differences in effectiveness and safety compared to the originator biologic drug. Patients can expect the same results from biosimilars as the originator biologic they are familiar with. Biosimilar drugs are made by name brand drug manufacturers.

Is it safe to transition from an originator biologic drug to its biosimilar version?

Yes. Biosimilars must meet strict regulations and testing requirements by Health Canada to prove they are as safe and effective as the originator biologic. Regarding the safety of biosimilars, Health Canada has clearly stated that its rigorous standards for approval ensure patients and health care providers can have the same confidence in the quality, safety, and effectiveness of a biosimilar as the originator biologic. In Canada and internationally, there have not been any unexpected safety issues identified for biosimilars.

Many plans in European countries have required patients taking originator biologics to switch to biosimilars for years. There are now more than 150 research studies across various medical conditions in rheumatology, gastroenterology, and dermatology that collectively show no meaningful clinical differences when patients are switched from an originator biologic to a biosimilar version.

Based on that experience and research, the provincial drug plan in British Columbia became the first in Canada to require biosimilar switching in 2019. Based on the success seen in British Columbia in terms of patients being able to successfully and safely transition to a biosimilar, and the savings realized by the provincial plan, every province in Canada now requires patients covered under provincial drug plans, including the Ontario Drug Benefit Program, to move to biosimilars where available.

Is a biosimilar drug the same as a generic?

No. A generic drug is a simpler molecule and can copy exactly the original brand name medication. Biologic drugs are made from live cells and are more complex than traditional drugs. Biosimilar drugs are highly similar to their originator biologic drug and work in the same way.

Please note that prescribers cannot use the "No Substitution" clause to have the originator biologic drug automatically dispensed under the benefit plan. An exception request must be submitted to FACET requesting continuation of the originator biologic for consideration. There must be a justifiable clinical reason to remain on the originator biologic.

Why do biosimilars cost less than originator biologics?

Biologic manufacturers spend years studying a new drug before it can be authorized for sale. The manufacturer then holds a patent on that drug that prevents other manufacturers from selling their own version of it. This allows the originator biologic manufacturer to earn back the money invested in researching and bringing the drug to market. When the patent of an originator biologic expires, other manufacturers can then produce biosimilar versions, which does not carry the same upfront research and development costs of a brand-new originator biologic.

Why do I have to switch to a specific *preferred* biosimilar, when there are multiple biosimilars on the market?

Biosimilars help reduce drug costs by increasing competition, which lowers prices over time. As more biosimilars enter the market, drug plans have the ability to negotiate preferential pricing to maximize savings. By selecting a preferred biosimilar, the Plan can secure significantly lower costs while continuing to provide coverage for essential medications. These savings help ensure that drug benefits remain available for all plan members.

Are there any exemptions to the biosimilar switch requirement?

Yes. Individuals in the following situations are not required to transition to a biosimilar equivalent:

- Pregnant women are excluded from the initial transition but must make the transition to the biosimilar within 6 months following delivery.
- Pediatric patients are excluded from the initial transition but must make the transition within 6 months following their 18th birthday.

If you fall into one of the two exempted groups, please make sure your physician completes Part 4: Biosimilar Transition Exemptions of the Biosimilar Switch Form.

If you do **not** fall into one of these two categories but your prescribing physician believes that switching to a biosimilar is not clinically advisable, your physician should provide detailed clinical rationale when completing **Part 5** of the Biosimilar Switch Form. These cases will be reviewed on an individual basis.

What biologic products are being transitioned?

This change will impact you if you are taking any of the following originator biologics:

Originator/Reference Biologic	Ingredient	Biosimilar
Remicade®	*Infliximab*	Renflexis®*
Humira®	*Adalimumab*	Idacio®*
Enbrel®	*Etanercept*	Brenzys®*
Copaxone®	*Glatiramer acetate*	Glactect®, Teva-Glatiramer Acetate®
Rituxan®	*Rituximab*	Riabni®, Riximyo®, Ruxience®, Truxima®
Stelara®	*Ustekinumab*	Otulfi®*
Lucentis®	*Ranibizumab*	Byooviz®, Ranopto®

* Preferred biosimilar under the Plan

If you are taking any of the medications mentioned above, you will require a new prescription to continue to receive coverage for your medication(s). This new prescription will allow you to transition from the originator biologic drug that you are currently on, to a biosimilar version. We encourage you to speak to your healthcare professional to discuss this transition.

I received a biosimilar transition letter, what do I need to do next?

If you have received a letter regarding the biosimilar switch plan design change, and are receiving one of the originator biologics listed above, you will need to:

1) Review the Enclosed Information – We have included a list of affected drugs and their biosimilar alternatives.
2) Consult Your Doctor – Discuss this change with your physician to ensure a smooth transition to the biosimilar
3) Complete the Biosimilar Switch Form – Have your doctor fill out the enclosed form and submit it to the FACET Prior Authorization Program.
4) Submit the Form – Fax the completed form to 1-844-446-1575 or email a scanned copy to claims@facetprogram.ca before the indicated deadline to avoid any disruption in coverage.

Please make sure you have contacted the FACET Prior Authorization Program by the deadline indicated on the letter so there is enough time to complete the required administrative work and ensure your reimbursement is not interrupted.

Please note that prescribers cannot use the "No Substitution" phrase on a prescription to have the originator biologic drug automatically dispensed under the benefit plan. An exception request must be submitted to FACET

requesting continuation of the originator biologic for consideration. There must be a justifiable clinical reason to remain on the originator biologic.

8. Medical Cannabis Overview

Why do I need preauthorization for medical cannabis when I can simply buy cannabis online or from a store?

While cannabis is legally available for purchase in Canada, the plan has a limited and specific list of medical conditions where cannabis may be considered for coverage, based on current clinical evidence and guidelines.

Prior Authorization is required to confirm that cannabis is being used to treat one of these approved conditions (see below), and that other standard therapies have been tried where appropriate. This process helps ensure that the plan is covering cannabis only when medically necessary, and in cases where there is a solid evidence base to support its use.

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 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.

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.

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.

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

Disclaimer: This FAQ has been developed by TEIBAS and FACET. The information provided here is for informational purposes only about the IBEW Local 353 Health and Welfare Plan in plain language. If there are any discrepancies between the information provided here and the legal documents that govern the plans, the legal documents will apply. The Trustees expect to maintain these benefit plans indefinitely. However, they reserve the right to change or cancel any or all benefits under the Health and Welfare Plan, for active and retired members, and their survivors and dependents.