ALBERTA BLUE CROSS®

OPIOID AGONIST THERAPY (OAT) GAP COVERAGE PROGRAM EXTENSION REQUEST FORM

Please complete all required sections to allow your request to be processed.

The OAT Gap Coverage Program provides immediate, no cost temporary coverage for OAT medications for up to 120 days for Albertans who **do not** have current drug coverage.

An Extension to the OAT Gap Coverage Program may be considered if the patient has applied for drug coverage (government-sponsored, employer plan or individual plan) and is waiting for that coverage to become active. To be considered for an Extension **this form must be completed and submitted to Alberta Blue Cross by fax (see fax number below).**

Patient last name	**Patient first name**	**Initial**	**Birth date** (YYYY-MM-DD)	
Street address	**City**		**Province**	**Postal code**
Alberta personal health number	**Phone number**			

Drug requested: ☐ Buprenorphine/naloxone sublingual tablets (e.g. Suboxone)
☐ Buprenorphine extended-release injection (e.g. Sublocade)
☐ Methadone liquid (e.g. Metadol-D, Methadose)

Does the patient currently have drug coverage through another health benefits plan?

☐ Yes - If yes, you are not eligible for the OAT Gap Coverage Program. This form is not applicable.
☐ No

If 'No' above, has the patient applied for drug coverage?

☐ Yes
☐ No – If no, the patient has not yet applied for drug coverage, this form is not applicable.

If 'Yes' above, please provide the following information:

Date of application (YYYY-MM-DD):_____ Health benefits coverage start date (YYYY-MM-DD): _____
Note: The Health benefits coverage start date does not represent the OAT Gap Coverage start date.

Type of drug coverage applied for:

☐ Employer plan ☐ Individual plan ☐ Government plan (e.g. Non-Group Coverage, Income Support)

If someone other than the patient is completing this form, please provide the following information:

Extension of OAT Gap Coverage is requested by: Last name _____ First name _____

Phone number: _____ Fax number: _____

Role: ☐ Caretaker ☐ Prescriber ☐ Pharmacist ☐ Social worker ☐ Other _____

Signature required for Extension to be considered. I confirm that the information in this form is accurate and that the patient has applied for drug coverage benefits that have not become active.

Signature (required): **X** _____ **Date** (YYYY-MM-DD)**:** _____

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-330-5211

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