Your request has been submitted. Thank you for your submission. Please print/save your application for your personal records. For any further inquiries, please contact at 1-844-648-7944 or send an email to Outofcountrylabsgenetics@ontario.ca.

Ontario

Ministry of Health

Application for Prior Approval for Full Payment of Insured Out-of-Country (OOC) & Out-of-Province (OOP) Laboratory & Genetics Testing

Instructions

A practising Ontario physician must complete the sections of this form that pertain to their request.

If you require clarification or additional information in order to complete this application form, please call ministry's toll-free number **1–844–648–7944**, or send an e-mail inquiry to: Outofcountrylabsgenetics@ontario.ca.

This form is designed to be completed and submitted electronically. Mandatory fields must be completed, or the form cannot be submitted to the ministry for review.

Information about the OOC/OOP prior approval program can be found on the ministry's website at: http://www.health.gov.on.ca/en/public/programs/ohip/outofcountry/prior_approval.aspx.

Before submitting, please verify that your patient's health card is valid. Any funding application submitted with an expired health card cannot be processed by the ministry. https://www.ontario.ca/page/health-card-renewal.

Please Do Not Complete This Online Application Form If:

- You do not know the answer to the questions in Part 4. In most cases, you will have to research the availability of current services in Ontario and wait times in several areas of the province.
- The required testing has already been rendered as services will be ineligible for reimbursement.
- You are requesting Emergency/911/CritiCall Transfers and Medical treatment/health services such as cancer treatment, bariatric surgery, MRI, etc. If these services are required, please complete the Request for Prior Approval for Full Payment of Insured OOC Health Services Form.

Fields marked with an asterisk (*) are mandatory.

Are you providing additional information for a previous submitted application? *

☐Yes ☐No

Please confirm if you are: (Select one) *

☐Ordering Ontario Physician/Physician Office Staff

☐OOC/OOP Laboratory

Previous PA Number * Ordering Ontario Physician/Physician Office Staff/ OOC/OOP Laboratory Email Address *

Comments

Is this a request for a Multigene Breast Tumour Profiling Assay? *

☐Yes ☐No

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Is the OOC/OOP testing required as a result of a work-related accident? *

☐Yes ☐No

If yes, **do not** complete this form. Please complete a Health Professional's Report (Form 8) and contact the Workplace Safety and Insurance Board (WSIB) at www.wsib.on.ca to discuss coverage. OHIP does not insure service(s) to which a person is entitled under the *Workplace Safety and Insurance Act*. The Workplace Safety Insurance Board (WSIB) can be reached toll free at 1-800-387-0750 or by mail at 200 Front Street West, Toronto ON M5V 3J1.

Please select one of the following to identify the destination of this request. *

☐Requested testing is for an Out-of-Country (OOC) Laboratory/Hospital

☐Requested testing is for an Out-of-Province (OOP) Laboratory/Hospital

Please select one of the following to identify the priority level the requested test is. *

☐**Category 1:** Testing needed for extremely time-sensitive and life-altering treatment decisions AND where a laboratory can turn around a result in <14 days

Examples:

- Prenatal tests that directly impact pregnancy options and management
- Tumor profiling that guides treatment
- Testing that can impact a time sensitive transplant
- Testing that will impact initiation of a time sensitive transformative drug treatment.

☐**Category 2:** Other testing where results will change or influence short term patient management decisions.

Examples:

- Testing in patients with severe symptoms and clearly defined treatment options depending on the test results
- Testing for evolving conditions
- Testing where results will help inform prognosis and guide next steps for health care providers and caregivers.

☐**Category 3:** Testing where results will not change or influence short term patient management decisions.

Examples:

- Conditions associated with future complications
- Testing for patients with mild symptoms
- Carrier or familial variant testing for unaffected patients
- Surveillance testing for chronic conditions or for conditions that require constant monitoring
- Post-mortem analysis to inform a relative about risks and prevention.

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Part 1 – Patient Information

• When completing this section, the Ontario physician's office should verify that the patient's health number and address are current and correct.

• If the patient is under the age of 16, the parent or legal guardian must sign on the patient's behalf.

• If the application is signed on behalf of a person over the age of 16 who is not the applicant, documentation must be provided which establishes that the person signing the form is legally authorized to do so. Acceptable documentation includes, for example, Power of Attorney for property or personal care.

Is the requested testing for a newborn with no Health Card Number? *

☐Yes ☐No

Is the requested testing for a deceased patient or stillborn? * Date of Death (yyyy/mm/dd) *

☐Yes ☐No

Is this application related to a pregnancy? *

☐Yes ☐No

This testing is for the: *

☐Mother ☐Current Fetus ☐Partner and/or Affected Family Member ☐Previously Deceased Fetus

Last Name * First Name *

Middle Name Date of Birth (yyyy/mm/dd) * Expected Delivery Date (yyyy/mm/dd) * age *

Sex * Ontario Health Card Number * Version Code

☐Male ☐Female ☐Non-binary ☐Do not wish to identify

Current Mailing Address

Postal Code * (if necessary, continue to select the Postal Code Lookup button until your correct address is shown)

Unit Number Street Number * Street Name *

PO Box/Rural Route/General Delivery City/Town * Province/Territory *

ON

Telephone Number (Preferred) * Telephone Number (Alternate)

ext.

Email Address (if available)

Is the patient under the age of 16? *

☐Yes ☐No

Please indicate the relationship between the applicant and the person completing the form. *

☐parent of child under 16 years of age ☐legal guardian ☐attorney under power of attorney

Parent, Legal Guardian or Power of Attorney

Last Name * First Name *

Part 2 – Referring Ontario Physician

- Please provide your name, OHIP billing number, most current specialty, office address, and email address. Please also provide a telephone number where the ministry can reach you.
- If your office telephone does not accept messages, please provide an alternate number such as your private line. Please provide the fax number you would like your decision letter faxed to.

Provider Billing No. * Last Name * First Name *

Office Address

Postal Code * (if necessary, continue to select the Postal Code Lookup button until your correct address is shown)

Unit Number Street Number * Street Name *

PO Box/Rural Route/General Delivery City/Town * Province/Territory *

ON

Telephone Number where we can reach you * Fax Number * Fax Number (Alternate)

ext.

Physician's work/practice setting/affiliation *

☐Hospital ☐Community Clinic ☐Both

Physicians Speciality * Email Address *

Physician/Clinic Support or Contact Staff

Last Name First Name

Telephone Number where we can reach you Email Address

ext.

Part 3 – Proposed OOC Health Facility / Diagnostic Laboratory / Hospital

Please provide the name, postal address, fax number, and email address of the OOC/OOP laboratory.

Laboratory/Hospital Name * Facility Number

Address * (maximum 250 characters)

Fax Number *

Part 4 – Testing Requested

- This section must be fully completed and must include the clinical diagnosis in full and the reason the service is required. You are also required to advise if this patient has made a previous attempt to receive this genetic test in Ontario and/or OOC/OOP.
- Please specify genetic test(s) requested and attach a **copy of the laboratory requisition.**
- Applications received without a copy of the laboratory requisition will be considered incomplete and will not be processed until the necessary documentation has been provided.

Clinical Diagnosis (condition for which treatment is sought) * (maximum 250 characters)

Reason Service is Required * (maximum 250 characters)

ICD-11 Mortality and Morbidity Statistics (ICD-11 MMS) Code for the Clinical Diagnosis Selected *

Name of Laboratory Test(s) Required *

Laboratory Test(s) Code

Have you previously requested and/or obtained this service in Ontario? *

☐Yes ☐No

Have you previously requested and/or obtained this service outside of Ontario? *

☐Yes ☐No

Specify when and where and provide reason for reapplication *

Is there an identical or equivalent test for this condition available in Ontario? *

☐Yes ☐No

Specify where and provide reasons for applying for out-of-country or out-of-province *

Is this a genetic test? *

☐Yes ☐No

Part 1 – Supporting Documents

Part 5 – Supporting Documents

Attach a copy of document which establishes that status or provide a consent signed by the patient permitting you to apply and communicate with the ministry on behalf of the patient if form is signed on behalf of person over the age of 16.

Attach a copy of the laboratory requisition and other supporting documents.

The total size of all attachments must not be more than 12 MB.

1 File Name Comments

*

Total File Size

Date of Submission PA Number

Part 2 – Signatures

Part 6 – Signatures

This application must be e-signed and dated by the referring Ontario physician who must attest that the application has been discussed with the patient (or their authorized representative).

I confirm: *

☐ that the requested testing is within my scope of practice and all the regulatory criteria required for the requested OOC/OOP testing have been met.

Or

☐ that the requested testing is not within my scope of practice and the appropriate specialist has confirmed that all the regulatory criteria required for the requested OOC/OOP testing have been met.

Please provide the names of the consulted appropriate specialist has confirmed that all the regulatory criteria required for the requested OOC/OOP testing have been met.

Specialist Last Name *

Specialist First Name *

☐ I know that the requested testing(s) is/are not an examination or procedure for the purpose of a research or survey program other than an assessment that is necessary to determine if an insured person is suitable for the program. *

☐ I know that the requested testing(s) is/are generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person. *

☐ I know that the requested testing(s) is/are not performed in Ontario. *

☐ I understand that a written approval must be received from the ministry before OOC/OOP laboratory & genetic testing is rendered. *

☐ I understand that OHIP does not cover the cost of transporting the sample to the proposed OOC/OOP laboratory. *

☐ I understand and have informed the patient or relevant substitute decision maker, that any funding, if approved, for this testing does not set precedent for future approvals for funding for the same testing or any other tests. The General Manager of OHIP reserves the right to deny funding for the same testing in any future applications based on applicable guidance, that may be updated from time to time, related to the requested testing. *

☐ I understand that the information in this application and any information relating to this application, including all accompanying documents, will be considered as part of this application. *

☐ I understand that the ministry or its agents acting on behalf of the ministry, such as Ontario Health, may collect, use or disclose personal health information and/or records relating to this application for the purposes of the administration of the *Health Insurance Act* including the administration of the OOC/OOP PA program. *

☐ I confirm that the patient or relevant substitute decision-maker has been informed by me that the patient's personal health information may be collected, used and disclosed by Ontario Health on behalf of the ministry as its agent under the *Personal Health Information Protect Act, 2004*, as part of this application process in order to make the appropriate assessment regarding the patient's eligibility to receive funding and any other assistance as may requested by the ministry for the administration of the OOC/OOP PA program. This may include the disclosure of the funding decision to me, as the referring physician, and to the requested out-of-country/out-of-province laboratory, if applicable. *

☐ I have reviewed the above statements and the completed application with the patient and attest that consent relating to this application has been provided by the patient or relevant substitute decision maker. *

I confirm: *

☐ that the requested testing is within my scope of practice and all the regulatory criteria required for the requested OOC/OOP testing have been met.

or

☐ that the requested testing is not within my scope of practice and the appropriate specialist has confirmed that all the following regulatory criteria required for the requested OOC/OOP testing have been met.

Please provide the names of the consulted appropriate specialist has confirmed that all the regulatory criteria required for the requested OOC/OOP testing have been met.

Specialist Last Name *

Specialist First Name *

☐ I know that the requested testing(s) is/are not an examination or procedure for the purpose of a research or survey program other than an assessment that is necessary to determine if an insured person is suitable for the program. *

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☐ I have reviewed the above statements and the completed application with the patient and attest that consent relating to this application has been provided by the patient or relevant substitute decision maker. *

Date of Submission

PA Number

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