Ontario Ministry of Health

Special Authorization (Allergen) - SAA

Instructions

Fields marked with an asterisk (*) are mandatory.

Section A - To be completed by Prescriber

Dear Prescriber:
The Ministry of Health funds the cost of certain allergen extracts supplied to eligible persons under the Ontario Drug Benefit Program. This form must be completed in order for the allergen extract to be funded for an eligible person. Please ensure that Section A of the form is completed before forwarding this authorization form to the allergen extract supplier or pharmacy. This form is valid for one prescription for the allergen extract described in this form and any refills authorized under that prescription, and may be used for up to two (2) years from the date it is signed by the prescriber.

Prescriber Information

Prescriber Last Name *	Prescriber First Name *	Middle Initial

Prescriber I.D. (Regulatory College Registration #)*

Prescriber I.D. Reference Code* ☐01 – CPSO ☐44 – CNO

Patient Information

Patient Last Name *	Patient First Name *	Middle Initial
Patient Date of Birth (yyyy/mm/dd)	**ODB Eligibility/Health No.** *	Version

Contents and concentration of allergen extract

Signature

Date (yyyy/mm/dd) *	Prescriber Signature *

Section B - To be completed by Dispensary

Dear Dispenser:
The Ministry of Health funds the cost of certain allergen extracts supplied to eligible persons under the Ontario Drug Benefit Program. This form must be completed in order for the allergen extract to be funded for an eligible person. Please ensure that the form is completed and signed before submitting a claim for payment to the ministry. This form is valid for two (2) years commencing on the date it is signed by the prescriber and applies to the allergen extract described in this form that has been prescribed by the prescriber and any renewals of that prescription. For any allergen extract that is not described in this form or that has been prescribed by another prescriber, a new form is required.

Ticket Number	☐Check box if Not a Duplicate	Date of Service (yyyy/mm/dd)

ODP Dispensary Number	Plan Code	Long Term Care Agency I.D. (if applicable)	DIN/PIN

SAA Number	Quantity *	Days Supply *	Drug Cost

Mark Up	Fee	Special Service Code (SSC)	Amount Billed To ODB

Contents and concentration of allergen extract.

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If allergen is a manufacturer's product, list the Drug Identification Number.

☐ Check box if contents and concentration of allergen extract is the same as in Section A.

Signature

The information contained in this form, including those on paper and electronic media, is being collected under the *Personal Health Information Protection Act*, *2004* and the *Ontario Drug Benefit Act* for the purpose of administering Ontario Public Drug Programs. For information contact: Director, Drug Programs Policy and Strategy Branch, 3rd Floor, 5700 Yonge Street, Toronto ON M2M 4K5 or call 416-327-8109.

I hereby certify that the Allergen Extract product being billed to Ontario Public Drug Programs herein has been provided on the date of service indicated in Section B to the patient identified above, and that the drug cost, mark up, and dispensing fee indicated in Section B incorporates the actual acquisition cost of the allergen product(s) with the eligible mark-up set out in ministry guidelines only, and includes no other costs (i.e. does not include costs for training, costs for time, other professional fees, equipment used in preparation, packaging of the product, or delivery of the product).

Submit this Claim to: **Ministry of Health**
Claims Services Branch
Fax: **1-613-237-3246**

Name	Authorized Signature *	Date (yyyy/mm/dd) *

Note: Please refer to the Ontario Drug Programs Reference Manual to review the retention period applicable for this record.