New Nouveau Brunswick

New Brunswick Prescription Drug Program
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Moncton, NB E1C 8M7

Telephone: 506-867-4515
Toll Free: 1-800-332-3692
Fax: 506-867-4872
Toll Free Fax: 1-888-455-8322
Website: www.gnb.ca/NBPDP

Organ Transplant Plan Application Form

The Organ Transplant Plan is a provincial drug plan that provides coverage for certain anti-rejection drugs for eligible New Brunswick residents. New Brunswick residents who have received a solid organ or bone marrow transplant may apply if they:

- have a valid New Brunswick Medicare card, and
- do not have coverage for any portion of the cost of anti-rejection drugs from any other drug plan.

More information is available online at www.gnb.ca/NBPDP or by contacting the inquiry line at (506) 867-4515.
Mail or fax your completed application and any supporting documentation to the address or fax number above.

Before your transplant

- If you are on a waiting list for a transplant, you may send your application form before receiving your transplant. The annual premium of $50 is not required until after you have received your transplant.

After your transplant

- A letter indicating that you do not have coverage for the anti-rejection drug(s) you are prescribed is required from your private plan (if applicable).
- The annual premium of $50 must be paid online, or by cheque or money order made payable to the New Brunswick Prescription Drug Program. Cash is not accepted.
- Your coverage under the Organ Transplant Plan must be renewed annually. Information on renewing your coverage will be mailed to you at least two months prior to the deadline of June 30th.

SECTION 1 - Applicant Information

First Name: _____ Last Name: _____

Address: _____

City/Town/Village: _____ Province: _____ Postal Code ___ ___

Telephone: (___)___-___ Gender: ☐ M ☐ F ☐ X

Medicare Number: ___ ___ ___ Date of Birth: D D M M Y Y Y Y

Language Preference: ☐ English ☐ French Type of transplant (organ): _____

Have you received your transplant? ☐ Yes ☐ No Transplant Date: D D M M Y Y Y Y

SECTION 2 - Other Drug Coverage

Are you currently enrolled in another drug plan that covers any of your drugs? ☐ Yes ☐ No

This includes drug plans through an employer, spouse, parent/guardian, federal or provincial government.

If yes, after your transplant, you must provide a letter from your private plan confirming that you do not have coverage for any portion of the drugs you have been prescribed.

Name of Insurance Company: _____

Policy Number: _____ Identification Number: _____

Name of employer or organization that sponsors the plan (if applicable): _____

Does your insurance company require you to apply to the Organ Transplant Plan? ☐ Yes ☐ No

FORM-810E 01/24

SECTION 3 - Personal Declaration and Authorization

By signing this application form, I confirm that:

I am applying to become a member of the New Brunswick Prescription Drug Program – **Organ Transplant Plan**, and I am providing information on this form for this purpose.

I understand that I can withdraw my application and cancel my membership at any time.

The information provided on this form is true to the best of my knowledge. I understand that knowingly providing false or incomplete information is an offence.

I authorize the New Brunswick Prescription Drug Program to collect my information from Medicare, the New Brunswick Organ Procurement Office and other sources to verify the information on this form and to verify eligibility for the New Brunswick Prescription Drug Program.

I authorize the New Brunswick Prescription Drug Program to communicate with my third-party insurance providers or patient support programs and act on my behalf to facilitate the processing of my application and administer my drug coverage.

I agree to notify the New Brunswick Prescription Drug Program immediately of any changes that may affect my coverage.

I understand that the personal information I provide, as well as any other personal information currently held or collected in the future, may be collected, used or disclosed to administer the New Brunswick Prescription Drug Program.

I authorize the New Brunswick Prescription Drug Program to collect, use and disclose my personal information as described above for as long as I remain a member of the New Brunswick Prescription Drug Program.

I understand that I can revoke my consent at any time. In some instances, revoking my consent may prevent the New Brunswick Prescription Drug Program from providing me with the requested coverage or benefits.

X Sign here - Applicant: _____ Date signed: D D M M Y Y Y Y

The name and signature of a parent/guardian is required if:

- The applicant is under the age of 16; or
- The applicant is between the ages of 16 and 18 (inclusive) and does not have the capacity to sign the personal declaration and authorization; or
- The applicant is 19 years of age or older and does not have the capacity to sign the personal declaration and authorization, or has given legal authority for another person to act on their behalf. Please attach a copy of the Power of Attorney for personal care. If you do not have Power of Attorney, please contact the New Brunswick Prescription Drug Program.

Name of parent/guardian: _____

X Sign here - Parent/Guardian: _____ Date signed: D D M M Y Y Y Y

This information is collected under the authority of the *Prescription Drug Payment Act*, SNB 1975, c P-15.01, s 2. This information will be used and disclosed to administer the New Brunswick Prescription Drug Program. It may be used and disclosed in accordance with the *Personal Health Information Privacy and Access Act*, SNB 2009, c P-7.05. For more information regarding the collection and use of personal information, visit www.gnb.ca/healthprivacy.