EXCEPTION REQUEST FORM

FOR COVERAGE OF ADDITIONAL DISPENSING FEES ASSOCIATED WITH COMPLIANCE PACKAGING & MAINTENANCE MEDICATION FILL LIMITS

SECTION 1: PLAN MEMBER DECLARATION

PLAN MEMBER NAME:	**GSC ID #:**

I have requested that my regular maintenance medications be supplied in:
☐ A prescription bottle(s), to be dispensed every_____days.
☐ A compliance package, to be dispensed every_____days. I am aware that compliance packaging is not child-safe.

My pharmacist has explained that compliance packaging and/or dispensing of my maintenance medications at a frequency greater than three months will be provided at an added cost to my plan sponsor (e.g. my employer). A dispensing fee will be charged each time my medication or compliance package is dispensed. I also understand that extra dispensing fees may cause me to reach or exceed any applicable benefit plan maximums.

PLAN MEMBER SIGNATURE:

SECTION 2: PHARMACIST DECLARATION

It is in my professional judgment that the above GSC plan member should receive medication in a

☐ _____day interval (request to exempt from Maintenance Medication Fill Limits), or
☐ _____day compliance package (request to exempt from Compliance Packaging requirements)

and be reimbursed for the applicable dispensing fee(s) for the following reason(s):

☐ Multiple chronic medications that are excluded from the GSC defined list of Maintenance Drugs, and/or
☐ Physical and/or Cognitive impairment, and/or
☐ Multiple disease states contributing to poor adherence

Note: If a resident of an assisted living facility, use intervention code "MY = Long Term Care Rx Split for Compliance".

Please use the space below to provide information supporting the above clinical need for dispensing medication at a frequency greater than every three months, or via compliance packaging, whichever is applicable:

_____

_____

_____

DATE:	**PHARMACIST SIGNATURE:**
GSC PROVIDER #:	**PHARMACY PHONE #:**
PHARMACY NAME:	**PHARMACY FAX #:**

SECTION 3: FORM SUBMISSION INSTRUCTIONS

1. *Please complete all sections of the form in full.*
2. Fax the completed form to the Green Shield Canada Drug Special Authorization Department at 519-739-6483 or toll-free 1-866-797-6483.
3. You will receive notification of approval or denial via faxed response.
4. A copy of this form should be retained in the pharmacy. Should there be any discrepancies with your submitted claim and the above information, your account will be adjusted accordingly.