Request for Approval of Brand-Name Drug

The prescribed drug you are applying for as an exception is covered up to the lowest cost interchangeable price. If this exception is approved, you will receive reimbursement up to the reasonable and customary price for the product dispensed. Some plans do not allow for reimbursement of brand name drug where generic(s) exist. Depending on the details of your plan, you may not be eligible for reimbursement of brand name drug.
The cost of the prescribed drug will only be considered under this plan provided the prescribing physician indicates that the lowest cost interchangeable drug(s) cannot be tolerated or are ineffective for the patient.

To apply for an exception, please complete Sections 1 and 3 and have your physician complete Section 2.

SECTION 1 PATIENT INFORMATION

Surname	Green Shield I.D. #	Employer Name	
First Name	Date of Birth (Y/M/D)	Telephone Number	
Street Address	City	Province	Postal Code

SECTION 2 – PHYSICIAN'S STATEMENT (any charges for the completion of this form are the responsibility of the plan member)

Section 2 must be completed in full by the prescriber. At least two different generic brands must be trialed, and the entire section below must be fully completed for each generic trialed for consideration. In unique cases where only one generic brand is available on the market, only one generic brand is required to be trialed.

Generic #1 ______________________ DIN ______________

Manufacturer ______________________ Regimen______________________

Dates of use______________________

Adverse Event:______________________

Date of adverse event: __________

Severity:

Life threatening ☐ Admitted to hospital ☐ Disability ☐ Needed Medical Attention ☐

Was report filed with Health Canada Yes ☐ No ☐

Was report submitted to manufacturer Yes ☐ No ☐

Generic #2 ______________________ DIN ______________

Manufacturer ______________________ Regimen______________________

Dates of use______________________

Adverse Event:______________________

Date of adverse event: __________

Severity:

Life threatening ☐ Admitted to hospital ☐ Disability ☐ Needed Medical Attention ☐

Was report filed with Health Canada Yes ☐ No ☐

Was report submitted to manufacturer Yes ☐ No ☐

Physician Name	Telephone Number
Street Address	Fax Number
City Province Postal Code	
Physician Signature	Date Signed (Y / M / D)

SECTION 3 AUTHORIZATION (please sign and date here)

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

_______________________________ _______________________________

Signature of Plan Member **Date Signed**

SECTION 4 MAILING INSTRUCTIONS

Once completed, return request form along with any original paid "Official Pharmacy" receipts to:

Green Shield Canada, Drug Special Authorization Department
P.O. Box 1606
Windsor ON N9A 6W1

Forms can be faxed or emailed: Fax: 1-519-739-6483 or Toll Free: 1-866-797-6483 or Email: drugspecial.autho@greenshield.ca