



## 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

Patient Name	Plan Member ID		
Email Address	Date of Birth (YY/MM/DD)	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 (YY/MM/DD)		

**SECTION 3 - AUTHORIZATION AND CONSENT (please sign and date here)**

At Green Shield Canada Insurance (“GreenShield,” “we,” “us” or “our”), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, “you” or “your”), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of GreenShield, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer’s group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GreenShield’s third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at [www.greenshield.ca](http://www.greenshield.ca), which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on [www.greenshield.ca](http://www.greenshield.ca). You can contact our Privacy Officer at [privacy.office@greenshield.ca](mailto:privacy.office@greenshield.ca) if you have a question or complaint.

**By signing below, you are providing your consent to GreenShield’s collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GreenShield at [privacy.office@greenshield.ca](mailto:privacy.office@greenshield.ca), but, if you do so, GreenShield will no longer be able to administer your benefits plan and process your claims.**

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Name	Signature	Date
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**SECTION 4 - MAILING INSTRUCTIONS**

Once completed, return request form along with any original paid "Official Pharmacy" receipts to:  
**Green Shield Canada Insurance, Drug Special Authorization Department**  
**P.O. Box 1606**  
**Windsor, ON N9A 6W1**  
**Forms can be faxed: Fax: 1-519-739-6483 or Toll Free: 1-866-797-6483 or Email: [drugspecial.autho@greenshield.ca](mailto:drugspecial.autho@greenshield.ca)**