BIOSIMILAR EXCEPTION REQUEST
SPECIAL AUTHORIZATION REQUEST FORM

Please note: Incomplete and/or missing information may delay your request for processing.

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**	

Please provide us with information on other coverage (provincial or private) as it pertains to this patient and medication:

Applied for coverage: ☐ Yes ☐ No ☐ Approved ☐ Denied ☐ Does not meet criteria for coverage

Secondary GSC Coverage: ☐ Yes ☐ No Member I.D. # _____

SECTION 2 – PRESCRIBER INFORMATION

Prescriber Name	**Prescriber Signature**	**Specialty**	**Date (Y/M/D)**
Street Address		**Telephone Number**	
City **Province** **Postal Code**		**Fax Number**	

SECTION 3 – DRUG REQUESTED FOR EVALUATION

DRUG REQUESTED: _____

DIAGNOSIS: _____

Please attach all relevant documentation to support below requests:

1. Provide details regarding disease course, including all applicable clinical assessment scores.

2. Provide previous and current medications used for this disease state, including date, dose, duration of use and treatment outcome.

3. Provide clinical rationale for why patient is unable to use or switch to a biosimilar.

4. If patient has tried the biosimilar(s), please provide the following:
- **Date(s) of use**
- **Duration(s) of use**
- **Rationale it was not effective (including supporting laboratory values and/or documented adverse effects)**

5. Any additional information to support this request.

SECTION 4 – MAILING INSTRUCTIONS

Once completed, return request form to: **Green Shield Canada, Drug Special Authorization Department, Appeal**

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

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.