NexgenRx Inc.
145 The West Mall
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Toronto, Ontario
M8Z 5M4

GROUP BENEFITS REQUEST

SPECIAL EVALUATION DRUG EXCEPTION

Please complete this form when requesting coverage for a prescription drug normally not eligible on your Group Plan. Request is for an individual Plan Member and their dependants. The request will be reviewed by NexgenRx Provider Services for approval.

- Return by fax to 1-877-639-4369 OR email providerservices@nexgenrx.com
- For privacy reasons, please do not contact or send this form to your Employer.

ALL FIELDS ARE MANDATORY

SECTION 1 **BENEFIT PLAN AND PLAN MEMBER INFORMATION** You can obtain your Group /Contract No. and your Certificate No. from your Benefit Card.	Group / Contract No.	Certificate No.	Plan Sponsor / Employer
	Plan Member / Employee Name (First, Middle Initial, Last)		Birth date (dd/mm/yyyy)
	Address		Phone Number & Email Address
	City / Town	Province	Postal Code
	Spouse's Certificate No. and Name (only if employed by the same Employer)		

SECTION 2 **PATIENT INFORMATION**	**Complete Patient's Name**	Date of Birth (dd/mm/yyyy)	Relationship to Plan Member

SECTION 3 **REQUEST FOR DRUG EXCEPTION** To be completed by Physician.	**NAME / STRENGTH OF PRESCRIPTION DRUG**	**DIN**
	Physician Name Address (Please Print) **Signature of Physician:**	Physician's Phone # Specialty: License #

SECTION 4 **MEDICAL DETAILS** To be completed by Physician.	This medication may not be covered at 100% because there is a therapeutic alternative ***OR it is not included on our standard formulary*** and is currently only covered at a lower percentage. The 'Exception' process is required for review and consideration of coverage. As with the Prior Authorization group of drugs this request requires that the health care provider completes the form and ***gives medical reasons including other medications tried in the past for this condition/disease state and any additional information relevant to the request. This also applies to Special Evaluation drugs***. Please indicate if the patient is covered under another drug plan or is eligible for a government program or is enrolled in a Patient Assistance Program sponsored by a pharmaceutical manufacturer. ***Please note that only the Indications published in the Product Monograph submitted to Health Canada will be considered***. When Exception requests have been considered and a cardholder exception is granted for a period of time ***the percentage out of pocket co-pay that has been agreed by the plan sponsor will remain the same as with any eligible drug.***

SECTION 5 **AUTHORIZATION** **MEMBER**	I certify that the information provided for this claim is true and complete. I understand that access to my personal information will be limited to NexgenRx employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access; and persons authorized by law. I agree a photocopy or electronic version of this authorization is valid. I understand that NexgenRx Privacy Policy and Privacy Information Package are available at www.nexgenrx.com. **I authorize NexgenRx to contact, and obtain personal information from any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim. I also authorize NexgenRx to disclose any such personal information to medical professionals for matters related to this claim.** I understand expenses incurred by the completion of this form are the plan member's responsibility. Also the approved medication will be adjudicated according to the plan structure.	
	Plan Member Signature	Date (dd/mm/yyyy)

CLIENT / PLAN SPONSOR / EMPLOYER / BROKER PLEASE NOTE:

Special Evaluation Exception Drugs that are " not standardly covered " on the plan are not eligible for Stop Loss pooling.

CLIENT / PLAN SPONSOR / EMPLOYER / BROKER SIGNATURE MANDATORY:
I acknowledge the exclusion from the Stop Loss coverage.

Print Name: SIGNATURE: DATE: