145 The West Mall, P.O. Box 110 U
Toronto, ON. M8Z 5M4

GROUP BENEFITS REQUEST SPECIAL EVALUATION DRUG EXCEPTION REQUEST FOR EXCEPTION

Instructions:

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist.

Please submit completed form to NexgenRx Provider Services via fax: 1-877-639-4369; mail: 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4; or email providerservices@nexgenrx.com
This NexgenRx form will be the property of NexgenRx with your authorized signature and gives permission to email/fax the "Specialty Program" your Employer has agreed to.

<u>All Fields Are Mandatory:</u> Incomplete forms may result in your application being declined

Section 1: To be completed by Patient

Carrier ID			Policy Group Number								Certificate Number												Patient Code		
9	8																								

Member's Name: (Last, First)	Employer:	
<u>Patient's Name: (Last, First)</u>	Patient's Date of Birth Date (dd/mm/yyyy)	Relationship to Member: ☐ Employee ☐ Spouse ☐ Dependent
Coordination of Benefits: Patient has other coverage? ☐ Yes ☐ No		
Patient's Complete Address:		

Street Name	Apt Number	City	Province	Postal Code

Results of this request to be communicated to:

Patient/Legal Guardian Named Below:	Patients email:	Patient's Phone Number: ( ) -

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of participating in this clinical patient support program and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist, other health care professional or agent having knowledge of such patient's health relevant to this request and any related claim. You give authorization to have this form provided to the "Specialty Program" your Employer has agreed to.
I consent to be contacted by the Program via phone, text or email and to the transfer of personal information by phone, fax or email between the Program, my insurer, and my health care provider(s) for the purpose of determining my eligibility for the Program and the delivery of Program services. Email and text may be used during the course of my participation in the program to inform me about my status in the Program and Program services, and to provide notifications and reminders. I acknowledge that neither email nor text are secure methods of communication. Information in emails and texts has the potential to be accessed and read by a third party. Electronic communication is at my option and I may withdraw this option to communicate electronically at any time.

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Patient/Legal Guardian Name:	Telephone Number: ( ) -
Signature of Patient/Legal Guardian:	Date (dd/mm/yyyy)

Are you enrolled in a Patient Support Program? ☐ Yes ☐ No If yes state which program:	
Support Program Case Worker Name:	Telephone Number: ( ) -
Fax Number: ( ) -	Case Worker email:
Do you provide consent to allow NexgenRx and or the Case Worker at the Specialty Program approved by your Employer to contact the patient support program? ☐ Yes ☐ No	
Do you have Provincial Coverage or have you applied for Provincial Coverage? ☐ Yes ☐ No	

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Section 2: To be completed by Physician

Drug Name & Strength:	DIN:	Dosage Instructions:

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. Similar to 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 note that only the Indications published in the Product Monograph submitted to Health Canada will be considered.

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 indicate what other medications the Patient has tried and the adverse effects.

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.*

Physician Name: (Last, First)	License Number: Specialty:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician: ______________________________	Date (dd/mm/yy)

201905_DrugBenSpEvalExcp_Drug_NGX__v05

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GROUP BENEFITS REQUEST SPECIAL EVALUATION DRUG EXCEPTION REQUEST FOR EXCEPTION

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: ___ Pharmacist's Name: (**Print** Last, First) ___	

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:

Internal Office Use Only:

Date Received:	Start Date:	End Date:	Date Approved: