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

HealthWATCH® Drug Plan Specialty Solutions Program
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)

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 will be emailed to the HealthWATCH® Drug Plan Specialty Solutions Program once our department/staff has completed their review.

All Fields Are Mandatory: 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:	
Patient's Name: (Last, First)	Patient's Date of Birth (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 HealthWATCH® Drug Plan Specialty Solutions Program.
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.

Patient/Legal Guardian Name:	Telephone Number: ( ) -
Signature of Patient/Legal Guardian:	Date (DD/MM/YYYY):

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Are you enrolled in a Patient Support Program? ☐ Yes ☐ No
If yes please 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 HealthWATCH® Drug Plan Specialty Solutions Program to contact the patient support program?
☐ Yes ☐ No

Do you have Provincial Coverage or have you applied for Provincial Coverage? ☐ Yes ☐ No

Section 2: To be completed by Physician

Drug Name & Strength:	DIN:	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying Health Canada criteria.
***Please note that only the Indications published in the Product Monograph submitted to Health Canada will be considered*.**
Please indicate the qualifying criteria for drug coverage:

Physician Name: (PRINT Last, First)			
License Number:	Specialty:	Telephone Number: ( ) -	Fax Number: ( ) -
Address:			
Street Name	Apt Number	City	Province / Postal Code
Signature of Physician:		Date (DD/MM/YYYY)	

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

Internal Office Use Only: Date Received:	Start Date:	End Date:	Date Approved & By:
			SHN email address: nexgenrxspecialty@sdmshn.ca

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