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

HealthWATCH® Tier Drug Plan
DRUG EXCEPTION REQUEST

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.

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 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		

To be eligible for coverage, trial with two alternative drugs may be required. Your exception request will be reviewed and a decision will be communicated to you via email or phone. Completion of this form is not a guarantee of approval.

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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 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 other parties your Employer has agreed to.
I consent to be contacted by the Program Representative other than NexgenRx 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 is 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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Section 2: To be completed by Physician

Drug Name & Strength:	DIN:	Dosage Instructions:

This patient's drug benefits include a two-tiered managed drug plan. Under the plan design this drug is not reimbursed at the higher coverage level, as there are other more cost-effective options available. The member has advised that there are medical reasons why they cannot use the alternative lower cost treatment and is seeking higher reimbursement. In order to assess eligibility, NexgenRx requires additional medical information to review the claim(s).

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

Please indicate previously tried therapy and clinical outcomes/adverse effects.

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

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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) _____	

Internal Office Use Only:

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