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

# NXG – CLINICAL PATIENT SUPPORT 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)
3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Provider Services to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4

## All Fields Are Mandatory:

### Section 1: To be completed by Patient

| Member's Name: (Last, First) | Card ID Number: | | |
|---|---|---|---|
| **Patient's Name: (Last, First)** | Patient's Date of Birth (dd/mm/yy) | Relationship to Member (please circle)<br>Employee Spouse Dependent | PATIENT CODE |

**Results of this request to be communicated to:**

| ☐ Pharmacy | ☐ Patient / Legal Guardian Named Below | ☐ Patient's email: |
|---|---|---|

**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.**

Patient / Legal Guardian Name: ____________________________________________________Telephone Number: _______________________ _______

**Signature of Patient/ Legal Guardian**: ____________________________________________ Date (dd/mm/yy):_______________________

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 to contact the patient support program? Yes ____ No ______



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## 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:<br>Specialty: |
|---|---|
| Address: (Street, City, Province, Postal Code) | Telephone Number : ( ) -<br>Fax Number: ( ) - |
| Signature of Physician: | Date (dd/mm/yy) |

## Section 3: To be completed by Pharmacist

| Pharmacy Name: | Provider Number: |
|---|---|
| Pharmacy Address: (Street, City, Province, Postal Code) | Telephone Number : ( ) -<br>Fax Number: ( ) - |
| Signature of Pharmacist: ______________________<br>Pharmacist's Name: (Print Last, First) ______________________ | |

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

## Internal Office Use Only:

| Date Received: | | | Date Approved & By: |
|---|---|---|---|