NO STAPLES PLEASE, PAPER CLIPS ONLY

Request for Approval of Brand-Name Drug

The prescribed drug you are applying for as an exception is covered up to the lowest cost interchangeable price. If this exception is approved you will receive reimbursement up to the reasonable and customary price for the product dispensed.
The cost of the prescribed drug will only be considered under this plan provided the prescribing physician indicates that the lowest cost interchangeable drug cannot be tolerated or is ineffective for the patient.

To apply for an exception, please complete Sections 1 and 3 and have your physician complete Section 2.

SECTION 1 - PATIENT INFORMATION

Surname	OTIP ID	Email Address
First Name	Date of Birth (YY/MM/DD)	Telephone Number
Street Address	City / Province / Postal Code	

SECTION 2 - PHYSICIAN'S STATEMENT (any charges for the completion of this form are the responsibility of the plan member)

Section 2 must be completed in full by the prescriber with a report filled with Health Canada's vigilance Program and submitted to the manufacturer for each generic tried

Generic #1 ______________________ **DIN** ______________________

Manufacturer ______________________ **Regimen** ______________________

Dates of use ______________________

Adverse Event ______________________

Date of adverse event ______________________

Severity:

Life threatening ☐ Admitted to hospital ☐ Disability ☐ Needed Medical Attention ☐

Was report filed with Health Canada Yes ☐ No ☐

Was report submitted to manufacturer Yes ☐ No ☐

Generic #2 ______________________ **DIN** ______________________

Manufacturer ______________________ **Regimen** ______________________

Dates of use ______________________

Adverse Event ______________________

Date of adverse event ______________________

Severity:

Life threatening ☐ Admitted to hospital ☐ Disability ☐ Needed Medical Attention ☐

Was report filed with Health Canada Yes ☐ No ☐

Was report submitted to manufacturer Yes ☐ No ☐

Physician Name	Telephone Number
Street Address	Fax Number
City / Province	Postal Code
Physician Signature	Date Signed (YY/MM/DD)

SECTION 3 – AUTHORIZATION (please sign and date here)

I certify that I, and/or my eligible dependants ("Dependants"), have received all good or services claimed and that the information provided for this claim is true and complete.

I authorize OTIP and its service providers to collect, use, maintain and disclose personal information relevant to this claim (“Information”) for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim (“Purposes”).

I am authorized by my Dependants to disclose and receive their Information for the Purpose. I authorize any person or organization with Information, including any medical and health professionals, facilities or provider, professional regulatory bodies, any employer, plan benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP and its service providers for the Purposes.

I authorize the use of my OTIP ID number for the purposes of identification and administration, I agree a photocopy or electronic version of this authorization is valid.

I acknowledge that more specific details regarding how and why OTIP collects, uses, maintains, and discloses my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or by request.

I understand that any Information provided to or collected for the Purposes in accordance with this authorization, will be kept in a benefits health file.

Access to the Information will be limited to:

- **OTIP and its service providers in the performance of their jobs;**
- **Persons to whom I have granted access; and**
- **Persons authorized by law.**

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

______________________________ ____________________

Signature of Plan Member **Date Signed**

SECTION 4 - MAILING INSTRUCTIONS

Once completed, return request form along with any original paid "Official Pharmacy" receipts to:

ATTN: Drug Special Authorization Department
P.O. Box 1606
Windsor, ON
N9A 6W1

Forms can be faxed: Fax: 1.519.739.6483 or Toll Free: 1.866.797.6483