

Request for Drug Exception Form

(For list of drugs covered – Refer to page 1)

In order for your exception to be considered you must have previously tried a covered drug for your medical condition and either the drug was not effective or you have a contraindication to the drug.



From anywhere... to anyone

Use this form to request coverage of a *drug that is not automatically covered* under your drug plan. **Provide the requested information to ensure timely assessment of your claim.**

Do not use this form for drugs that require PRIOR AUTHORIZATION. Please refer to page one (1) for the list of Prior Authorization drugs which are indicated in ***bold italics***. The Prior Authorization forms can be found at canadapost.ca/drugplan or call Great-West Life at 1-866-716-1313.

PLAN MEMBER INFORMATION

Please select your plan number:

- 51391** or
 162954 (MGT/XMT who retired on or after January 2, 2011)

Employee/Retiree ID #:

Name:

Address:

PATIENT INFORMATION

Name:

Relationship:

Date of Birth:

Drug Name:

Would you like Great-West Life to contact you by telephone upon completion of the exception review? **Yes** **No**

If yes, please indicate the phone number where they can reach you and leave a message should you be unable to answer: (____) _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect is used for the purpose of assessing eligibility for this drug and for administering the group benefits plan. I authorize Great-West Life, my physician or healthcare provider, and TELUS Health Solutions to exchange information when necessary for these purposes.

Patient/Guardian's signature: _____ Date: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

Attending Physician Name:

Registration Number:

Address:

Telephone Number:

Fax Number:

Required Information

To obtain coverage for the drug, one other covered pharmacotherapy must have been tried in the past, unless contraindication exists.

What is the health condition being treated with this drug?

Is the drug prescribed to treat a health condition for which the specific drug use is approved by Health Canada? **Yes** **No**

Did the patient previously try a medication (pharmacotherapy) to treat this health condition? **Yes** **No**

If yes, list the **specific names** of other medications (pharmacotherapies) used to treat the health condition?

If no other medication (pharmacotherapy) was tried, please explain why this drug must be prescribed (for example a contraindication resulting from an allergy reaction):

Information on requested drug

Drug Name:

Dose Prescribed:

Physician's signature: _____ Date: _____

Once completed, the Request for Drug Exception Form can be returned to Great-West Life at the address or fax number below.

Fax to: The Great-West Life Assurance Company
Fax Number: 1 866 239-7140
Attention: Drug Services

Mail to: The Great-West Life Assurance Company
Drug Services P.O. Box 6000
Winnipeg MB R3C 0E6