THE Great-West Life ASSURANCE COMPANY

Drug Exception Request Form

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.**

PLAN MEMBER INFORMATION	
Policy Number:	Student Name:
Student ID #:	Address:

PATIENT INFORMATION		
Patient:	Relationship:	Date of Birth:

I hereby authorize The Great-West Life Assurance Company to use the information provided herein and/or consult with the below stated physician to determine eligibility for special authorization drug benefits.

Student/Patient's signature: _____ Date: _____

BRITISH COLUMBIA, SASKATCHEWAN OR MANITOBA residents:

If you are a resident of British Columbia, Saskatchewan or Manitoba and the requested drug has been approved by the Provincial Drug Program on an exception basis, please send us a copy of the government approval letter. (If this section applies to you, then you do not need to complete the remainder of this form.) Coverage will be added to your Pay Direct Drug Card (myBenefits Card) within 2 -3 days.

PLEASE HAVE THE FOLLOWING COMPLETED BY YOUR PHYSICIAN:	
Physician's Name:	Registration Number:
Address:	
Telephone Number:	Fax Number:

REQUIRED INFORMATION	
In order to be considered for a drug exception, you must have tried at least one medication on your plan's applicable formulary.	
Diagnosis:	
Drug prescribed and DIN #, if known:	
Alternative treatments attempted (Please provide specific drug names and din #'s, if known. Please note this request will not be considered if this section is not completed).	
If no other medication 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: _____

It is important that all of the above information is provided in detail to avoid delay in assessing claims for the above drug. Please note that the plan does not cover any fees for providing information. Once completed, this form can be returned to Great-West Life at the address, fax # or email shown below.

Mail to: The Great-West Life Assurance Company
PO Box 6000
Winnipeg MB R3C 3A5
Canada
Attention: Drug Services

Fax to: Drug Services
The Great-West Life Assurance Company
Fax 1.204.946.7664

Email to: gwldrug.services@gwl.ca

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