



# EXCEPTION REQUEST FORM

## FOR COVERAGE OF ADDITIONAL DISPENSING FEES ASSOCIATED WITH COMPLIANCE PACKAGING & MAINTENANCE MEDICATION FILL LIMITS

SECTION 1: PLAN MEMBER DECLARATION	
PLAN MEMBER NAME:	GSC ID #:
<p>I have requested that my regular maintenance medications be supplied in:</p> <p><input type="checkbox"/> A prescription bottle(s), to be dispensed every ____ days.</p> <p><input type="checkbox"/> A compliance package, to be dispensed every ____ days. I am aware that compliance packaging is not child-safe.</p> <p>My pharmacist has explained that compliance packaging and/or dispensing of my maintenance medications at a frequency greater than three months will be provided at an added cost to my plan sponsor (e.g. my employer). A dispensing fee will be charged each time my medication or compliance package is dispensed. I also understand that extra dispensing fees may cause me to reach or exceed any applicable benefit plan maximums.</p>	
PLAN MEMBER SIGNATURE:	
SECTION 2: PHARMACIST DECLARATION	
<p>It is in my professional judgment that the above GSC plan member should receive medication in a</p> <p><input type="checkbox"/> ____ day interval (request to exempt from Maintenance Medication Fill Limits), or</p> <p><input type="checkbox"/> ____ day compliance package (request to exempt from Compliance Packaging requirements)</p> <p>and be reimbursed for the applicable dispensing fee(s) for the following reason(s):</p> <p><input type="checkbox"/> Multiple chronic medications that are excluded from the GSC defined list of Maintenance Drugs, and/or</p> <p><input type="checkbox"/> Physical and/or Cognitive impairment, and/or</p> <p><input type="checkbox"/> Multiple disease states contributing to poor adherence</p> <p><i>Note: If a resident of an assisted living facility, use intervention code "MY = Long Term Care Rx Split for Compliance".</i></p>	
<p>Please use the space below to provide information supporting the above clinical need for dispensing medication at a frequency greater than every three months, or via compliance packaging, whichever is applicable:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
DATE:	PHARMACIST SIGNATURE:
GSC PROVIDER #:	PHARMACY PHONE #:
PHARMACY NAME:	PHARMACY FAX #:
SECTION 3: FORM SUBMISSION INSTRUCTIONS	
<ol style="list-style-type: none"><li>1. Please complete all sections of the form in full.</li><li>2. Fax the completed form to the Green Shield Canada Drug Special Authorization Department at 519-739-6483 or toll-free 1-866-797-6483.</li><li>3. You will receive notification of approval or denial via faxed response.</li><li>4. A copy of this form should be retained in the pharmacy. Should there be any discrepancies with your submitted claim and the above information, your account will be adjusted accordingly.</li></ol>	