



COMPOUND – APPEAL REQUEST SPECIAL AUTHORIZATION FORM

Please note: Incomplete and/or missing information may delay your request for processing.

SECTION 1 PATIENT INFORMATION

Surname	Green Shield I.D. #	Employer Name
First Name	Date of Birth (Y/M/D)	Telephone Number
Street Address	City	Province Postal Code

Please provide us with information on other coverage (provincial or private) as it pertains to this patient and medication:
 Applied for coverage: Yes No Approved Denied Does not meet criteria for coverage
 Secondary Coverage Provider: _____ Member I.D. # _____

SECTION 2 – PRESCRIBER INFORMATION

Prescriber Name	Specialty	Prescriber Signature	Date (Y/M/D)
Street Address	Telephone Number		
City	Province	Postal Code	Fax Number

SECTION 3 – COMPOUND REQUESTED FOR EVALUATION

COMPOUND REQUESTED: _____
 Active Ingredient: _____
 Route of Administration: _____

REQUESTED USE AND/OR DIAGNOSIS: _____

Provide detailed rationale as to why the patient cannot use a commercially available product:

Describe all drug alternatives that have been considered, and the rationale for them not being appropriate for the patient:

Is the requested use for this drug supported by standard practice and/or is it considered a standard of care? YES NO
 Please provide relevant consensus statement, practice guidelines, and/or other evidence supporting the requested use.

Is the requested use for this drug supported by clinical evidence? YES NO
 Please provide copies of at least two Phase II and/or Phase III clinical studies, demonstrating efficacy and safety.

Provide any additional information to support this request:

SECTION 5 – MAILING INSTRUCTIONS

Once completed, return request form to: **GreenShield, Claims Production Coordinators, Appeal**
 P.O. Box 1606, Windsor ON N9A 6W1
 Forms can be faxed or emailed: Fax: 1.519.739.6483 or Toll Free: 1.866.797.6483 or Email: ClaimsProductionCoordinators@greenshield.ca

Please note: Incomplete and/or missing information may delay your request for processing.
THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.