PRIOR AUTHORIZATION REQUEST
Drug Exception

INSTRUCTIONS

Please ensure that the following information is fully completed by your physician. If you are eligible by another plan (public or private) please have your physician indicate below. All expenses related to completion of form are those of the patient's.

Return completed form to:
Claims Department at RWAM Insurance Administrators Inc. Fax: 1-519-669-1923 Email: csr-groupclaims@rwam.com

SECTION 1 - PATIENT IDENTIFICATION

Group # _____ Certificate # _____ Date of Birth *(yy/mm/dd)* _____

Insured _____ Patient _____

Authorization: I understand the information I provide on this form will be used to determine my eligibility for group insurance benefits claimed under this policy/plan. I declare that the statements made on this form are complete and true. I hereby authorize the release to RWAM Insurance Administrators Inc., of any information in respect to this claim requested by RWAM. This authorization will remain valid for as long as I am claiming benefits or service, or revoked in writing by myself.

A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.
(The Patient is responsible for securing this form and for charges made for its completion.)

Insured _____ Patient's Signature _____ Date _____

SECTION 2 - PHYSICIAN IDENTIFICATION

Surname _____ Given Name _____

Specialty _____ Phone # _____

Physician's Signature _____ Date _____

SECTION 3 - DRUG EXCEPTION REQUIRING PRIOR AUTHORIZATION

1. Product Name _____ Strength _____

   Dose _____ Duration of Treatment _____

2. Diagnosis and Stage of Disease _____

3. Reason for Request: ☐ Contraindication ☐ Therapeutic failure ☐ Adverse reaction ☐ Other

   _____

   Please provide an explanation to expand on checked item(s).You may use the back of this form if additional space is needed.
   Attach any supporting documentation.

   _____

   _____

   _____

   _____

4. If applicable, please provide the location of administration of medication:

   ☐ Home/Self-Administered ☐ Hospital ☐ Hospital Clinic ☐ Doctor's Office ☐ Long-Term Care Facility ☐ Private Clinic

   Name of Private Clinic _____

   Address _____

5. If applicable, please provide information on other coverage (provincial or private) as it pertains to this patient and medication.

   Applied for other coverage: ☐ Yes ☐ No If 'Yes': ☐ Approved ☐ Denied

   Type of Coverage _____

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