GREEN SHIELD
CANADA

GENERIC DRUG EXCEPTION FORM

Please ensure all areas of this form are complete. Incomplete forms cannot be processed and will be returned to the patient. Please note that the submission of this information does not guarantee payment nor imply approval of a claim or anticipated claim.

SECTION 1 – PATIENT INFORMATION

Surname	**Green Shield I.D. #**		
First Name	**Telephone Number**		
Street Address	**City**	**Province**	**Postal Code**
Patient Name	Date of Birth (DD/MM/YY)		

SECTION 2 – PHYSICIAN INFORMATION

Physician Name	**Physician Signature**	**Date (Y/M/D)**
Street Address		
City **Province** **Postal Code**		

GENERIC DRUG RESULTING IN ADVERSE REACTION (to be completed by physician)

Name of Generic Drug resulting in adverse reaction:	**Dosage:**
Date of Reaction:	
Describe the nature, extent and severity of the adverse reaction:	

What was the outcome of the adverse reaction? (check all that apply)

( ) Life Threatening **( ) Hospitalization** **( ) Required Intervention to prevent impairment** **( ) Allergic Reaction**

( ) Other (please specify): ______________________________

Anticipated Duration of Therapy:	
Name of proposed treatment drug:	**Dosage:**

SECTION 3 – MAILING INSTRUCTIONS

Once completed, please return request to:

Green Shield Canada
Drug Special Authorization Department
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: drugspecial.autho@greenshield.ca

Coverage is contingent on your continued status as a Green Shield Canada cardholder or beneficiary.
Upon receipt, this request will be confidentially reviewed by Green Shield Canada.
Green Shield Canada will provide you with a written response.