GREEN SHIELD CANADA

PRESCRIPTION DRUG
SPECIAL AUTHORIZATION REQUEST FORM

Dear Plan Member:

Please have the following Prescription Drug Special Authorization form completed in full by your physician. If you are eligible for coverage by another plan (public or private) please have doctor indicate below. Your request will be reviewed and evaluated by our Drug Special Authorization Department who will communicate the results to you. Should you have any questions, you may contact our Customer Service Centre at 1-888-711-1119. **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	

I hereby authorize any licensed physician/dentist, medical practitioner, hospital, clinic or medically related facility, to give to Green Shield Canada information regarding my health. I hereby authorize Green Shield Canada to exchange information with other parties as required, only when the information is needed to administer this benefit and/or to confirm the accuracy of this information.

Date _____ **Signature of Patient** _____

(If under 14 years of age, the signature of the plan member is required.)

SECTION 2 – PHYSICIAN INFORMATION

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

SECTION 3 – DRUG REQUESTED FOR EVALUATION

Product Name/Strength/Dose/Duration of Treatment:	Diagnosis:

Injectable-location of administration (CHECK ONE):

- ☐ HOME
- ☐ PHYSICIAN'S OFFICE
- ☐ HOSPITAL (IN-PATIENT)
- ☐ HOSPITAL (OUT-PATIENT)
- ☐ LONG TERM CARE FACILITY

Previous Therapeutic History for above condition (Please include relevant lab results):	Contact Information:

Product name/dose/duration and results of prior treatment:

_____

_____

_____

_____

Additional comments pertaining to medication/medical condition:

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**

SECTION 4 – MAILING INSTRUCTIONS

Once completed, please return request along with any original paid "Official Pharmacy" receipts 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

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.