BRAND NAME
DRUG EXCEPTION FORM
FOR MANDATORY GENERIC PLANS ONLY

Your prescription drug plan includes coverage for up to the equivalent lowest cost alternative (typically the generic equivalent) of a brand name drug. We have received a request to consider coverage of a specific brand name drug on an exception basis. Please ensure that the following information is fully completed and returned to:

RWAM Insurance Administrators, 49 Industrial Drive, Elmira, Ontario N3B 3B1
Attention: Claims Department or it can be e-mailed to csr-groupclaims@rwam.com for assessment.

SECTION 1
To be completed by the PATIENT

Group # _____ Certificate # _____

Insured's Name _____ Patient's Name _____

SECTION 2
To be completed by the ATTENDING PHYSICIAN

☐ Attach a completed copy of the Health Canada Vigilance Adverse Reaction Reporting Form.
Recommended by Health Canada (http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/index-eng.php)
Available on their website at: http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/medeff/report-declaration/ar-ei_form-eng.pdf

OR Complete the following:

Patient Name _____

Name of Generic Drug resulting in adverse reaction _____

Describe the nature, extent and severity of the adverse reaction _____

_____

_____

Name of Proposed Treatment Drug _____

Dosage Form _____ Quantity _____

Physician's Name _____ Physician's Phone # _____

Physician's Address _____

_____

AUTHORIZATION - Patient and Physician

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 requested by RWAM in respect to this claim. 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.)

Patient's Signature _____ Date _____

Phone _____

Physician's Signature _____ Date _____

Phone _____