THE Great-West Life ASSURANCE COMPANY

REQUEST FOR COVERAGE OF EXCEPTION STATUS DRUG

Please complete the following:

Student Name: ______________________ Patient Name: ______________________

Policy Number & Student ID #: ______________________ Date of Birth: ______________________ (year/month/day)

Address: ______________________

I hereby authorize The Great-West Life Assurance Company to use the information provided herein and/or to consult with the below stated physician to determine eligibility for special authorization of drug benefits.

Student/Patient's signature: ______________________ Date: ______________________

Please have the following completed by your physician:

Physician Name: ______________________

Address: ______________________

Telephone No.: ______________________ Fax No.: ______________________

1. Diagnosis: ______________________
2. Drug prescribed and Din #, if known: ______________________
3. Reason for request: ______________________
4. Alternative treatments attempted:
   (Please provide specific drug names and din #'s, if known. Please note, this request will not be considered if this section is not completed).

Physician's signature: ______________________ Date: ______________________

It is important that all of the above information is provided in detail to avoid delay in assessing claims for the above drug. Please note that the plan does not cover any fees for providing this information. Once completed, this form can be returned to Great-West Life at the address or fax # shown below.

Mail to: The Great-West Life Assurance Company
Drug Services, P.O. Box 6000
Winnipeg, Manitoba R3C 3A5

Fax to: The Great-West Life Assurance Company
Fax Number: (204) 946-7838
Attention: Drug Services

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