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. If this application for exception is approved, you will be reimbursed up to the usual and customary price for the brand product dispensed. To be eligible for the coverage, the prescriber must indicate that there has been an adverse reaction or therapeutic failure to generics. Please refer to Health Canada's Canada Vigilance Adverse Reaction Reporting form for Health Canada's definition of a true adverse reaction.

The following information should be completed and returned to RWAM Insurance Administrators Inc. for assessment.

Email csr-groupclaims@rwam.com

Mail RWAM Insurance Administrators Inc.
49 Industrial Dr., Elmira, Ontario N3B 3B1
Attention: Claims Department

SECTION 1

To be completed by the PATIENT

Insured Name	Group #	Div.	Class	Certificate #
Patient Name		Patient Date of Birth (yyyy/mm/dd)		
Address #, Street City, Prov. PC select		Phone		

SECTION 2

To be completed by the PRESCRIBING HEALTHCARE PROFESSIONAL

Name of Generic Drug Prescribed (1) NOTE: 2 Generics must be tried	DIN# Generic Drug (1)
Describe the nature, extent, and severity of the adverse reaction or therapeutic failure	
Name of Generic Drug Prescribed (2)	DIN# Generic Drug (2)
Describe the nature, extent, and severity of the adverse reaction or therapeutic failure	
Name of Proposed Treatment Drug	DIN# Proposed Treatment Drug
Proposed Dosage Form	Quantity

HEALTHCARE PROFESSIONAL CONTACT INFORMATION

Name	Phone
Address #, Street City, Prov. PC select	

AUTHORIZATION - Patient and Healthcare Professional

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	
Prescriber's Signature	Date	