

# Drug Exception Request Form



ihaveaplan.ca

**Exceptions can only be granted for the current policy year.  
This form must be returned within 90 days of the first denied claim.**

**\*PLEASE NOTE THAT ANY MISSING INFORMATION MAY CAUSE FURTHER DELAYS.**

The exception will be considered for any medication that is not included on the provincial formulary and that has no other alternatives. The exception can only be requested for drugs which legally require a prescription. If you have already purchased the prescription, please attach the original receipt and the completed health claim form.

**NOTE:** the student plan does not cover vitamins, antihistamines, fertility, or smoking cessation products. Therefore, no exceptions will be made for these products.

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## Student's Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Student Number: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_  
Student Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_

### If this Request is for a Dependant:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth (MM/DD/YY): \_\_\_\_\_ Relationship to you: \_\_\_\_\_

### Exception Details

DIN #: \_\_\_\_\_  
First Date of Purchase During Current Policy Year: \_\_\_\_\_  
First Denied Claim (Date): \_\_\_\_\_  
Please Specify if it Was Denied by      Mail       or by the Pharmacist   
Student's Signature: \_\_\_\_\_

## Physician's Statement

Drug's Name: \_\_\_\_\_ \*DIN #: \_\_\_\_\_  
Reason for Exception (Diagnosis) \_\_\_\_\_  
Have you Tried an Alternative Drug Listed on the Formulary:     YES     NO  
If YES - Drug Treatment: \_\_\_\_\_  
DIN #: \_\_\_\_\_ Date: \_\_\_\_\_

### Prescribing Physician

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
License Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_  
Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For approval, please send form to:



studentcare.net/works  
1134 St. Catherine Street West, Suite 700  
Montreal, QC H3B 1H4