



## EXCEPTION DRUG STATUS REQUEST FORM

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day/Month/Year

### PATIENT IDENTIFICATION

Name: \_\_\_\_\_ Health Services Number: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day/Month/Year

Sex:  Male  Female

### DRUG INFORMATION (See Appendix A for specific criteria)

Drug(s) Requested: \_\_\_\_\_  
(include name, dosage form, and strength)

Diagnosis (be specific): \_\_\_\_\_  
(must be obtained from physician or physician's agent only - cannot be obtained from the patient)

obtained by:  Fax  Phone  Written on Rx

Alternative agents tried (be specific): \_\_\_\_\_

Drug allergies (be specific): \_\_\_\_\_

Drug intolerances (be specific): \_\_\_\_\_

Other information relevant to this request: \_\_\_\_\_

For Pharmacy Use Only	For Physician Use Only
Pharmacist Name: _____	Physician Name: _____
Pharmacy Name: _____	Physician M.S.P. Number: _____
Pharmacy Phone Number: _____	Locum for Dr. (if applicable): _____
Pharmacy Fax Number: _____	Address: _____
Prescribing Physician: _____	_____
Physician M.S.P. Number: _____	_____
Locum for Dr (if applicable): _____	Phone Number: _____

### DRUG PLAN USE ONLY

Fax Back Information:	HIRF INFO:	Drug Profile:
	<input type="checkbox"/> 30 <input type="checkbox"/> P1	_____
	<input type="checkbox"/> PC <input type="checkbox"/> P2	_____
	<input type="checkbox"/> SB <input type="checkbox"/> P3	_____