Application for Drug Exception

Email your completed form to:
studentbenefits@pbas.ca

Questions or concerns?
Toll-free: 1-888-404-6623

Exception to the Student Drug Formulary will only be granted if there is a medical need for a medication that is not included on the Student Drug Formulary. The exception will only be made for drugs which legally require a prescription and at least one alternative drug, eligible under the formulary, has been tried but was unsuccessful in treating your condition. To determine if your medications are covered, you may search www.studentbenefits.ca, follow the link to My Plan Services and the link to Eligible Drug Search. In order to use this site, you will require the Drug Identification Number (DIN) and/or Drug Name. Applications for drugs specifically excluded under the plan will not be considered. If you have already purchased the medications and you are requesting exceptions, you must complete a health claim form attaching all original receipts to assist with processing your claim.

Any expense for medical evidence to support your claim is the responsibility of the student.

PATIENT'S STATEMENT

Student Name:_____ Student ID No:_____
(*Surname*) (*Given*)

Patient Name:_____ Patients' DOB:_____
(*if applicable*) (*Surname*) (*Given*) (*if applicable*) (*Year/Month /Day*)

University / College:_____ Phone No: (____) _____

Address:_____
(*Street*) (*City*) (*Province*) (*Postal Code*)

I hearby authorize The Campus Trust to use the information provided herein and/or to consult with the physician named below to determine eligibility for special authorization of drug benefits. Email:_____

Students'/Patients' Signature _____ Date:_____

Please have the following section completed by your physician.

PHYSICIAN'S STATEMENT

Exception Requested:_____ _____
(*Drug Name*) (*Drug Identification Number (D.I.N.)*)

Reason For Exception:_____
(diagnosis)

Have you tried an alternative drug, eligible under the Formulary? Yes ○ No ○ N/A ○

If Yes,_____ Date tried:_____
(*Drug Name*) (*D.I.N.*) (*Year/Month /Day*)

If No, please attach a physician's note citing a medical reason why it would not be appropriate.

Attending Physician:_____ License #_____
(*Surname*) (*Given*)

Address: _____
(*Street*) (*City*) (*Province*) (*Postal Code*)

Email:_____ Phone # _____

Physician's Signature: _____ Date _____

www.studentbenefits.ca

Office Use Only **APPROVED** ☐ **DENIED** ☐

Signature Date