Drug Coverage Appeal Request

Drug Plan and Extended Benefits Branch
3475 Albert Street
REGINA SK S4S 6X6
Toll Free: 1-800-667-2549
Phone: 306-787-8744
Fax: 306-798-1089
Email: DPEB@health.gov.sk.ca

- This form is to be completed and signed by the prescriber or another health care provider.
- Complete the form to request coverage for a medication if:
  - the medication is not a Formulary benefit, or
  - the medication is used for a condition that does not meet the published Exception Drug Status (EDS) criteria. Clarify the clinical circumstances and provide **sufficient clinical evidence to strongly support the request** for consideration of coverage.
- **Note:** Submission of a complete form, with supporting clinical evidence, initiates the process for the request to be considered. A submission does NOT mean the request will be automatically approved.

Complete each section to avoid potential delays in review.

Section 1 - Prescriber Information

First Name: ______________________ Last Name: ______________________

Email Address: ______________________

Phone: ______________________ Fax: ______________________

Requester Name (if different from above): ______________________ Requester's preferred contact e-mail: ______________________

Section 2 – Patient Information

First Name: ______________________ Last Name: ______________________

Health Services Number: ______________________ Date of Birth: ______________________

Section 3 – Requested Drug Regimen and Clinical Information (may be attached in letter format if preferred)

1. Drug Requested: ______________________
2. Dosing Regimen and Route of Administration: ______________________
3. Duration of Therapy Requested: ______________________
4. Patient Diagnosis: ______________________
5. Clinical Presentation:
6. Additional Medical History or Clinical Details Relevant to the Request (may be attached in letter format if preferred):

7. Previous Therapies Tried and Response Achieved (include doses, dates and duration of trial and details of patient response):

Drug or Non-Drug Regimen Tried	**Dose**	**Dates and Duration of Trial**	**Detailed Patient Response to Trial Treatment**

8. Other Treatment Options Available and Why Those Alternatives Are Not Appropriate (should include details on ALL Formulary options that have not already been tried as well as other known treatment options that have been considered):

Alternative Treatment Options	**Reason(s) the Alternative Treatment Options Are NOT Appropriate**

9. Clinical Evidence* Relevant to the Request To Support Treatment

*A copy of the Journal article(s), the electronic link(s) or the complete citation(s) MUST be provided.
Please Note: Clinical evidence submitted should align with the request for this treatment, condition and patient.

10. What Outcome Measures Will be Monitored, and When Will This Monitoring Occur?

11. How Will Treatment Success Be Defined? (Note: Please include measurable outcomes.)

12. If Goals of Therapy Are NOT Met, What Will Be the Ongoing Treatment Plan?

Requester Signature: ______________________________ Date: _________________________

The third page may be submitted if any additional information is required to support this request.

13. Additional Information Relating to the Request: