Health and Social Services

MEDICAL CONFIDENTIAL

REQUEST FOR EXCEPTION DRUG/PRODUCT COVERAGE

[CHOOSE ONE] ☐ **Pharmacare - Seniors Program** ☐ **Chronic Disease**

Please Fax Back to: 393-6486 BEFORE: ___________________

PHYSICIAN INFORMATION:

Name: *Dr.*	**Billing Number:**

PATIENT INFORMATION:

Name:	**YHCIP #:** 002-

DRUG REQUESTED:

Drug Name:			**Drug ID Number (DIN):**
Dosage Form:	**Strength:**	**Schedule:**	**Anticipated duration:**
			FROM | | | **TO** | | |

DIAGNOSIS:

REASON FOR REQUEST:

For criteria see Yukon Drug Formulary

Physician

NOTE: Please include appropriate test results, previous drug history & any specialist recommendations that may be required for this patient.

Physician's Signature: Date:

Information is collected by the Department of Health and Social Services under the authority of several Acts, depending on the program. It is collected to determine eligibility for programs and/or level of services offered by the department. For more information please contact: Chronic Disease Program 667-5092 or Pharmacare Program 667-5403.

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