Request for Brand Name Drug Coverage

The information you provide on this form helps us assess your request for coverage of a brand name drug. **To be eligible for this coverage, medical evidence must show that you experience adverse side effects from the generic version.** If your request is approved, coverage may be granted for a set period of time, after which you'll need to re-apply for continued coverage. Assessment of your request may be delayed if this form is incomplete.

You are responsible for any fees associated with completing this form.

Complete the following section. Please print.

Plan member name	Patient name	
Plan name NB PIPE TRADES	Plan number 165578	Plan member certificate number
Address (number, street, city, province, postal code)		

At NexgenRx/NB Pipe Trades we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines or if you have questions about our personal information policies and practices (including with respect to service providers), write to NexgenRx's Chief Privacy Officer or refer to www.nexgenrx.com.

I authorize NexgenRx/NB Pipe Trades, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with NexgenRx/NB Pipe Trades, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing my consent will help NexgenRx/NB Pipe Trades to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I certify that the information given is true, correct and complete to the best of my knowledge.

Plan member's signature: _____ Date:_____

Ask your prescribing physician to complete the following section. Please print.

Name of prescribing physician	Speciality	
Address (number, street, city, province, postal code)		
Phone number		
Brand name drug requested	DIN	Dosage/frequency
Generic drug prescribed	DIN	Dosage/frequency
Outcome attributed to adverse reaction (check all that apply) ☐ Life threatening ☐ Hospitalization ☐ Allergic reaction ☐ Other (specify) _____	Description of adverse reaction (nature, extent, severity)	
Anticipated duration of therapy	Prescriber's signature	Date (dd/mm/yyyy)

Mail completed form to: NB Pipe Trades Admin Office, 5 Blizzard Street, Fredericton, NB E3B 8K3
Or by fax to: 506-458-1257 Attention: Claims Coordinator