EXCEPTION DRUG STATUS (EDS) REQUEST FORM

FAX: (204) 942-2030 or 1-877-208-3588

Please complete form by providing ALL necessary information.

Part 3 EDS criteria can be found at: http://www.gov.mb.ca/health/mdbif/docs/edsnotice.pdf

Prescriber Name:	**Fax Number:**
Prescriber Address:	**Phone Number:**
	Prescriber License Number (NOT Billing Number):

Patient First Name:	**PHIN:**	**MHSC:**
Patient Last Name:	**Patient's Date of Birth:**	
New Request ◯	**Renewal** ◯	
Medication, Strength, and Dosage Form:	**Regimen and Duration:**	
Diagnosis and Indication:		

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the EDS listing. Please provide the following details about how this patient meets the specific criteria for coverage. Manitoba Health may request additional documentation to support this EDS request.

Treatment History:

Name of Drug	*Dosing Regimen*	*Start Date*	*End Date (if applicable)*	*Outcome of Treatment*
				☐ Ineffective ☐ Intolerance ☐ Contraindication (please specify): ☐ Other:
				☐ Ineffective ☐ Intolerance ☐ Contraindication (please specify): ☐ Other:
				☐ Ineffective ☐ Intolerance ☐ Contraindication (please specify): ☐ Other:

Relevant Clinical Information:

☐ **I have discussed with the patient that the purpose of releasing their information to Manitoba Health, Seniors and Long-Term Care is to obtain Exception Drug Status for prescription coverage**

Date: **Prescriber Signature:**