EDS REQUEST FORM: PERSONAL CARE HOME

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

Personal Care Home (PCH) Name and Address:	**PCH Fax Number:** **PCH Phone Number:**
Prescriber Name:	**Prescriber License Number (NOT Billing Number):**

Resident First Name:	**PHIN:**	**MH Registration Number:**
Resident Last Name:	**Resident's Date of Birth:**	
Medication Name and Strength:	**Expected Dosing:**	**Expected Therapy Duration:**

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the Part 3 listing. Please provide the following details about how this patient meets the specific criteria for coverage:

Diagnosis/Indication:

Any previous or alternative therapies that have been tried, and any demonstrated and documented contraindications or side effects:

Additional Clinical Information:

Date: **Signature:**

For EDS office:

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