

Prescriber Information		
Name <input type="text"/>	Profession	Phone number/Fax number
Patient Information		
Name		Phone number
Health challenges, medical condition being treated		
Drug/Nutritional Product Request		
<small>(All Drugs and Nutritional Products requested must have a Drug Identification Number or Natural Product Number assigned to them by Health Canada.)</small>		
Drug requested (generic or brand name)	Strength/Dosage/Frequency	Duration of Prescription
Has the patient already tried this drug? For how long? Describe the results.		
As the prescriber, are you able to access samples of this drug on behalf of your patient for a trial period (at least one month)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
As the physician, are you involved in formal drug trials with the manufacturer of this pharmaceutical?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Drugs or Therapeutic Approaches Tried to Date		
Description Results		
Additional Information		
Other information which may be useful to the Health Benefits Exception Committee or the AISH Program in making their decision regarding funding for the requested drug (i.e. hospitalizations, health complications)		
Prescriber's Signature		Date (yyyy/mm/dd)

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