AUTHORIZATION FOR RESTRICTED DRUG USE

WUSA/GSA Health & Dental Plan

Once completed, please deliver the form to:

Studentcare
Health Services, Room 1006
200 University Avenue West
Waterloo, ON N2L 3G1

Student Name (Please print):	Student ID#:
Date of Birth (mm/dd/yyyy):	Phone Number:
Email address:	
Is this request for a dependent on your Plan? If so:	
Dependent Name (Please print):	Date of Birth (mm/dd/yyyy):

Diagnosis:	
Prior Medication or Treatment:	
1) Name:	Drug Identification Number (DIN):
Dates of Treatment:	
2) Name:	
Dates of Treatment:	
Request for Drug on Restricted Drug Usage list: *Note: The DIN(s) for the drug requested is needed before approval can be authorized.*	
Drug Name and dosage:	
Drug Identification Number from the pharmacy dispensing (DIN):	
First Date of Purchase:	
Reason:	
Prescribing Physician (Please print):	
Prescribing Physician Phone Number:	

FOR HEALTH SERVICES USE ONLY:
Medical Director's Authorization:
Effective Date: