

## WORKERS' COMPENSATION BOARD OF NOVA SCOTIA (WCBNS) MANDATORY GENERIC EXEMPTION REQUEST

Please complete all required sections to allow your request to be processed without delay.  
 This form must be completed by a Prescriber

Date: DD/MM/YYYY		
<b>PATIENT INFORMATION</b>		
<b>WCBNS Claim Number:</b> <i>Mandatory</i>	or new claim: <input type="checkbox"/>	DOB: DD/MM/YYYY
		HCN:
Worker's Last Name:	First:	MI:
Street address:		
P.O. Box:	City:	Postal Code:
<b>DRUG REQUESTED</b>		
Drug Name/Strength/Form/Dosage:	Diagnosis	
Medication History:		
Generic/Brand name tried	Date & Length of Therapy	Outcome
Other Relevant Information ( <i>description of adverse reaction including: nature, extent, severity</i> ):		
<b>PRESCRIBER INFORMATION</b>		<b>PLEASE RETURN FORM TO:</b>
Prescriber:	Prescriber Address:	<b>Medavie Blue Cross</b> <b>P.O. Box 2200,</b> <b>Halifax, NS B3J 3C6</b>  <b>Fax: (902) 496-5819</b>
License Number: (e.g. CPSNS, NANS, NSPhS, etc.)		
<b>Fax Number:</b> <i>Mandatory</i>		
Prescriber signature:		
For WCB Office use only: SA - Yes <input type="checkbox"/> No <input type="checkbox"/>		
Effective Date		Signature (Case Worker)