

AUTHORIZATION FOR RESTRICTED DRUG USE

WUSA/GSA Health & Dental Plan

Once completed, please deliver the form to:

ALUMO



**Alumo
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: <i>Note: The DIN(s) for the drug requested is needed before approval can be authorized.</i>	
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: