



# 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**

OR

**via email to:  
service@studentcare.ca**

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

Diagnosis:	
<b>Prior Medication or Treatment:</b>	
1) Name:	Drug Identification Number (DIN):
Dates of Treatment:	
2) Name:	
Dates of Treatment:	
<b>Request for Drug on Restricted Drug Usage list:</b>	
<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:	

<b>FOR HEALTH SERVICES USE ONLY:</b>
Medical Director's Authorization:
Effective Date: