EXCEPTIONAL REQUEST FORM: SHINGRIX® VACCINE

PROTECTED B WHEN COMPLETED

SECTION I: PROVIDER/PATIENT INFORMATION

Provider Name:		**Provider #:**
Provider Address:		
Provider Phone:	**Fax:**	**Date (dd/mm/yyyy):**
Patient's Surname:		**Given Name(s):**
DOB (dd/mm/yyyy):		**Gender:**
PHN:		**Status #:**
Pharmacy Name:	**Fax:**	**Pharmacy Phone:**
Product Requested: Shingrix®		**DIN: 02468425**

SECTION 2: TO BE COMPLETED BY PROVIDER

Requests are reviewed on a case-by-case basis. If approved, coverage is provided for a **maximum of two doses** of Shingrix®.

IMMUNODEFICIENCY OR IMMUNOSUPPRESSION:

Patient has an immunocompromising medical condition/diagnosis: ☐

Immunocompromising medical condition/diagnosis: _____

Patient is on or will be starting an immunocompromising treatment: ☐

Immunocompromising treatment: _____

Dosage and Frequency: _____ Expected duration of therapy: _____

Additional medical rationale supporting request for exceptional coverage of Shingrix®:

Please provide documentation if available.

Additional Comments/Specialist Name (if applicable):

Prescriber Signature: _____ **Date:** _____

FAX TOLL-FREE: : 1-888-299-9222 or Mail To: **Health Benefits**
First Nations Health Authority
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Vancouver, BC V6C 1A1

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