BIOSIMILAR SWITCHING EXEMPTION FORM
PEI BIOSIMILAR INITIATIVE

Fax requests to (902) 368-4905, email to drugprograms@gov.pe.ca **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1- PATIENT INFORMATION

PATIENT (FAMILY NAME)	PATIENT (GIVEN NAME)
DATE OF BIRTH (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)
PATIENT'S MAILING ADDRESS	

SECTION 2 – CONTACT INFORMATION OF PERSON COMPLETING FORM

☐ Patient completing the form (contact information provided) **OR**
☐ I am applying on behalf of the patient:
- ☐ Health Care Provider:
  - ☐ Profession: _____
  - ☐ License number: _____
  - ☐ Name: _____
  - ☐ Phone number: _____
  - ☐ Fax number: _____
- ☐ Other:
  - ☐ Relation to patient: _____
  - ☐ Name: _____
  - ☐ Phone number: _____

SECTION 2 - REASON FOR REQUESTING SWITCHING EXEMPTION

☐ **Pregnancy**
- Name of biologic drug: _____
- Due Date: _____
- Coverage for originator will be extended to 3 months after due date. Patients must switch to biosimilar within that 3-month period.

☐ **Biosimilar version of insulin is not yet shown to be compatible with insulin pump**
- Brand of Insulin: _____
- Pump make and model: _____
- Coverage of originator insulin will be extended until biosimilar insulin and pump compatibility is confirmed.

☐ **Unable to get an appointment with my prescriber before my special authorization is due for renewal.**
- Please note – this does not apply for patients who are on insulin and are required to switch to a biosimilar. A pharmacist can assist with switching to a biosimilar insulin.
- Name of biologic drug: _____
- Prescriber/specialist name: _____
- Appointment date: _____
- The special authorization for your biologic drug will be extended to 1 month following your upcoming appointment.
- **Originators will not be covered beyond Oct 31, 2024.**

NOTE:
- PEI Pharmacare may require additional documentation or information to support this request.
- Personal information on this form is collected under Prince Edward Island's Health Information Act as it relates directly to and is necessary for providing services under the PEI Pharmacare Drug Programs
- If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

SECTION 3 – DECLARATION

- I declare that the information provided on this application is true and correct to the best of my knowledge.
- I understand that providing false information may result in recovery of any benefits paid.

SIGNATURE (REQUIRED):	**DATE:**

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION