CONSEIL CRI DE LA SANTÉ ET DES SERVICES SOCIAUX DE LA BAIE JAMES
CREE BOARD OF HEALTH AND SOCIAL SERVICES OF JAMES BAY

RESERVED FOR BARCODE

File Number

Surname Given name

Health card (RAMQ) Date of birth (YYYY-MM-DD)

Mother: Surname, Given name

Father: Surname, Given name

Address Phone number

☐ Chisasibi CMC ☐ Chisasibi Hospital

☐ Eastmain ☐ Mistissini ☐ Nemaska ☐ Ouje-Bougoumou

☐ Waskaganish ☐ Waswanipi ☐ Wemindji ☐ Whapmagoostui

CNIHB FORM-ACCESS TO EXCEPTIONAL MEDICATION

Please attach the prescription and the completed form then send both documents by email to:
18tcr.medication.cnihb@ssss.gouv.qc.ca
Any incomplete application will be returned to the prescriber

SECTIONS 1 TO 5 MUST BE COMPLETED BY THE PRESCRIBER

1. PRESCRIBER INFORMATIONS

Full name: _____ Licence #: _____ Phone: _____

Email address: _____ Primary practice location: _____

2. PATIENT INFORMATIONS

Weight: _____ kg Date: _____ Most recent labs and other relevant data:

Height: _____ cm Date: _____ _____

ClCr/eGFR: _____ Date: _____ _____

Body surface area: _____ M^2 Date: _____

3. MEDICATION INFORMATIONS

Generic name: _____ Brand name: _____

Posology: _____ Duration/number of cycles: _____

Diagnosis: _____

Indication (and stage if applicable): _____

Treatment intention: _____

Approximate planned start date: _____

Was the treatment already started, if yes where: _____

4. REQUEST TYPE

☐ **Restricted use**	☐ **Special medical necessity**	☐ **Exceptional treatment**
• Covered under the RAMQ/NIHB/CNIHB formulary but with restricted or limited use based on specific criteria	• Health Canada Marketed medication not listed on the RAMQ/NIHB/CNIHB formulary • Health Canada Marketed medication used for an indication not included on the RAMQ/NIHB/CNIHB formulary	• Medication that is not marketed by Health Canada • Medication used for an indication not recognized in the Canadian product monograph

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6. JUSTIFICATION

- Justify why this medication should be used instead of formulary alternatives. Include relevant information such as prognosis, treatment goals, and the patient's clinical condition *(e.g., disease severity or stage, previous treatment response, etc.).*
- Explain how the patient meets specific criteria, if applicable.

- Describe the patient's adherence to prescribed treatments and comprehension of the treatment plan:

- Has the medication been evaluated by INESSS?
  - ☐ Yes. The characteristics of the user are different from those of the population evaluated by INESSS. (Specify)
  - ☐ Yes. The disease has characteristics different from those of the disease in the population evaluated by INESSS. (Specify)
  - ☐ Yes. New scientific data is available since then (Provide references)
  - ☐ No. (Provide references)

- Other/Comments:

☐ I confirm that I have obtained, at a minimum, the verbal free and informed consent of the user or their representative, if applicable, regarding the potential implementation of this treatment plan.

☐ I confirm that I will ensure appropriate clinical monitoring of treatment efficacy and safety, and I will discontinue the treatment in the event of therapeutic failure or intolerance.

Prescriber's Signature	**License**	**Date**

Send prescription + form to: 18tcr.medication.cnihb@ssss.gouv.qc.ca

SECTIONS RESERVED FOR ANALYSIS COMMITEE

Request number: _____

Receipt date of the request: _____

Date of evaluation by the committee: _____

Decision: ☐ **Approval** ☐ **Refusal** ☐ **Incomplete** * Valid for 1 year unless specified otherwise

Justification: _____

Analysis Committee Representative signature or Chief of Pharmacy Department signature

Name	**Signature**	**Date**