Generic Medical Partners Inc.

Section A: Healthcare Professional Recommender Details

(To be completed by the individual requesting compassionate access on behalf of a patient)

Full Name: _____
Title/Position: _____
Profession/Designation: _____
Qualifications: _____
Institution/Organization: _____
Department: _____
Institution Address: _____
Phone Number: _____
Email Address: _____

Section B: Patient Information

(Basic details to support request. Sensitive personal or medical details are not required.)

Patient Full Name: _____
Patient of (Name of Recommending Healthcare Professional or Institution):
_____
Requested GMP Medication: _____
Does the patient currently receive coverage for the requested medication?
☐ Full Coverage ☐ Partial Coverage ☐ No Coverage
Estimated out-of-pocket cost per month for patient: $ _____

Section C: Patient Situation Requiring Support

(To be completed by the recommending healthcare provider. Please describe the circumstances that justify compassionate access to medication.)

Section D: Supporting Healthcare Provider

(If different from Section A)

Full Name: _____
Title/Profession: _____
Institution/Clinic: _____
Contact Information: _____
Proposed Method of GMP medicine provision: _____

Section E: Healthcare Provider Signature & Submission Information

I confirm that the information provided in this application is accurate and truthful to the best of my knowledge. I am recommending compassionate access to medication in good faith, based on the patient's current situation and medical needs.

Signature: _____
Name (Printed): _____
Date: _____

Patient Basic Contact Information

(To be completed by healthcare provider or optionally by patient)

Phone Number: _____
Email Address: _____

Form Submission Instructions

Please submit the completed form to:

Generic Medical Partners Inc. – Compassionate Care Program

Email: customerservice@gmprx.com

Phone: (416)-444-4467

Fax: 1 (866)-259-2058

1500 Don Mills Road, North York, Suite 711

Toronto, ON, M3B 3K4

Canada