



SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of anti-TNF for Crohn's Disease

Pharmaceutical Services
 Department of Health and Community Services
 P.O. Box 8700, Confederation Bldg.
 St. John's, NL A1B 4J6

Phone: (709) 729-6507
 Toll Free Line: 1-888-222-0533
 Fax: (709) 729-2851

Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number
Address		Patient Weight (kg)

Diagnostic Information

Diagnosis <input type="checkbox"/> Active Moderate to Severe Crohn's <input type="checkbox"/> Induction <input type="checkbox"/> Maintenance <input type="checkbox"/> Fistulizing Crohn's <input type="checkbox"/> Other _____	CDAI score _____ Harvey Bradshaw Score _____
	Drug and Dose Requested _____ _____

5-ASA Products

Drug	Dose	Duration/Dates	Outcome

Glucocorticosteroids

Drug	Dose	Duration/Dates	Outcome

Immunosuppressive Therapy

Drug	Dose	Duration/Dates	Outcome

Antibiotic Therapy

Drug	Dose	Duration/Dates	Outcome

Additional Information

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Prescriber Information / Requested By:

Prescriber Name: _____ License Number: _____
 (please print)

Address: _____ Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Pharmacist Name: _____ Pharmacy Name: _____
 (optional) (optional)

Please note that Special Authorization Requests normally take approximately 10 working days to be processed.

Version June 2009 – Replaces previous forms