



SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)

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

Drug Requested for Special Authorization

Drug: _____ Dosage: _____ Duration: _____
 Patient Diagnosis: _____

Previous Medication Trial

Drug: _____ Dosage: _____ Duration: _____
 Trial Outcome: _____

Reason for Request

- contraindication therapeutic failure
 adverse event other

Explain: _____

Diagnostic Testing

Diagnosis confirmed via: _____ Date: _____

Other Comments: _____

Prescriber Information / Requested By: Physician Other Health Professional

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

Please copy additional forms as needed.