Newfoundland Labrador

SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of
COVERAGE CRITERIA FOR Oral Ciprofloxacin Tablets

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

Oral Ciprofloxacin Indication

Respiratory Tract Infections likely or proven to be caused by *Pseudomonas aeruginosa*:

☐	Exacerbation of COPD with or without bronchiectasis, with previous *Pseudomonas aeruginosa* colonization.
☐	Exacerbation of Cystic Fibrosis.

Genitourinary Tract Infections likely or proven to be caused by *Pseudomonas aeruginosa*:

☐	Bacterial prostatitis
☐	Anatomically complicated urinary tract infections without source control.
☐	Failure of previous therapy for urinary tract infection (persistent culture positive).

Skin and Soft Tissue Infections likely or proven to be caused by *Pseudomonas aeruginosa:*

☐	Malignant otitis externa
☐	Diabetic foot osteomyelitis

Gastrointestinal Infections with likely or proven to be caused by *Pseudomonas aeruginosa* including:

☐	Typhoid fever
☐	Gut perforation without surgical source control

Other:

☐	Outpatient febrile neutropenia
☐	Allergy or intolerance to other oral agents listed in Firstline (www.firstline.org) app.
☐	Gram negative bacilli from sterile culture which is resistant to other oral agents.
☐	Prophylaxis of close contacts of culture positive *N. meningitides,* as recommended by public health.
☐	Infectious Disease specialist recommendation date:

Dose:_____**Frequency:**_____

Duration:_____**days**

Culture:

Bacterial identification:_____

Specimen:_____

Collection date:_____

Prescriber Information / Requested By: ☐ Physician ☐ Other Health Professional

Address: _____ License Number: _____

Signature: Phone Number: _____ Fax Number: _____

Date: