SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

Methadone Maintenance Treatment: Daily Dispensing

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		

This form must be completed by Methadone Prescriber

Coverage will be for dispensing Methadone on a daily basis under the supervision of a healthcare professional for a minimum of two months after treatment initiation and until take-home dose coverage is requested by the Methadone prescriber when the patient is clinically stable and able to safely store take-home doses.

List of drug(s) of addiction:____

Has Physician-Patient Treatment agreement been signed? Yes:________ No:__________

Treatment Requested

□ Methadone Oral Solution

Initiation Date (dd-mm-yyyy) _______________

Additional Comments

Methadone Prescriber Information / Requested By:

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

Address: ____________________ Phone Number: ____________ Fax Number: __________

Signature: ______________________________ Date: ______________

Pharmacist Name: (optional) ____________________ Pharmacy Name: (optional) ____________________

Version December 2016 – Replaces previous forms