SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for CONTINUATION of Rheumatoid Arthritis Medications

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

Request for Continuation of Coverage

Drug Name	Dosage
Assessment Date	**Patient Weight (kg)**

Please indicate level of patient response: (e.g. Symptoms, joint counts & relative laboratory data).

	Please provide score:
☐ Rheumatoid Arthritis	☐ ACR ______ ☐ DAS _______ (rituximab only)
☐ Psoriatic Arthritis	☐ ACR ______ ☐ PsARC _____
☐ Ankylosing Spondylitis	☐ BASDAI _____ ☐ ASAS _____ ☐ HAQ _____

Comments:

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

Prescriber Name:
(please print) License Number:

Address: Phone Number: Fax Number:

Signature: Date:

Pharmacist Name:
(optional)

Pharmacy Name:
(optional)

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

Version December 2014 – Replaces previous forms