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: (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 June 2009 – Replaces previous forms

Please copy additional forms as needed.