e Z	SPECIAL AUTHORIZATION REQUEST FORM				
Jacoffee Manual	The Newfoundland and Labrador Prescription Drug Program (NLPDP) Request for Coverage of Inflixmab for Crohn's Disease				
Newfoundland	Pharmaceutical Services				
Labrador	Department of Health and		Phone:	(709) 729-6507	
	P.O. Box 8700, Confeder	lg.	Toll Free Line:		
	St. John's, NL A1B 4J6			Fax:	(709) 729-2851
Patient Information					
Patient Name		of Birth NLPDP Drug Card/MCP Number			
Address					Patient Weight (kg)
Diagnostic Information					
Diagnosis		2 1481			
_	erate to Severe Croł	ın's			
□ Fistulizing Crohn's			□ Other		
			Dose Requested		
5-ASA Products					
Drug Dose		Duration/Dates Outcome			
Glucocorticosteroids					
Drug			Duration/Dates	Outcome	
Immunosuppressive Therapy Drug Dose Duration/Dates Outcome					
Drug	Dose		Duration/Dates	0	utcome
Antibiotic Therapy					
Drug	Dose		Duration/Dates	O	utcome
Additional Information					

Name of GastroenterologistSignatureDate*Please note that Special Authorization Requests can take up to 10 working days to process.Version February 2007 – Replaces previous forms