



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 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: Explain: _____

contraindication

adverse event _____

therapeutic failure

other _____

Diagnostic Testing:

Diagnosis confirmed via: _____ Date _____

Other Comments: _____

Prescriber Information/ Requested by:

Prescriber Name: _____ License Number: _____ Phone Number: _____

Address: _____ Fax Number: _____

Pharmacist Signature: _____ Date: _____

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

Please copy additional forms as needed.