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 Building
St. John's, NL, A1B 4J6

Phone (709) 729-6507
Toll Free Line 1-888-222-0533
Fax (709) 729-2851

PATENT INFORMATION

Name ______________________________

Phone number ________________________

Address ______________________________

PHARMACY INFORMATION

Pharmacy Name _________________________________

Provider Number ________________________________

Pharmacy Telephone: _____________________________

Patient's NLPDP Drug Card Number (MCP number not applicable)
____

PHYSICIAN INFORMATION

Physician Name ______________________________ Phone number ___________________________

Address _____________________________________ Fax number ______________________________

DRUG REQUESTED FOR SPECIAL AUTHORIZATION

Product ________________________ Dosage___________________ Duration_____________

Samples Used ___________________________________ Dosage ______________________________

Patient diagnosis ____

Reason for Request:
- ☐ contraindication
- ☐ adverse event
- ☐ therapeutic failure
- ☐ other

Explain: ____
____
____

PROTON PUMP INHIBITORS (diagnostic information required):

Diagnosis confirmed via: Radiography_________ Endoscopy __________ Date _____________

H2 antagonist trial: Product_______________ Dosage _____________ Duration ________

Trial outcome ____

For H. Pylori eradication please choose the regimen requested (note all are bid for 7 days):

☐ ppi (indicate brand)_________or ☐ pylorid, plus clarithromycin 250mg, metronidazole 500mg

☐ ppi (indicate brand)_________or ☐ pylorid, plus clarithromycin 500mg, amoxicillin 1000mg

☐ HP- pac (lansoprazole 30mg, clarithromycin 500mg, amoxicillin 1000mg)

REQUESTED BY:

G physician signature ____________________________ Date_______________
G pharmacist signature ____________________________ Date _______________

Please copy additional forms as needed.