Reset Form

Health PEI

SPECIAL AUTHORIZATION REQUEST

STANDARD SPECIAL AUTHORIZATION

Fax requests to (902) 368-4905 **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)		PATIENT (FAMILY) NAME	PATIENT (GIVEN) NAME(S)
DATE OF BIRTH (YYYY/MM/DD)	PATIENT WEIGHT (kg)	PATIENT'S MAILING ADDRESS	

SECTION 2 – PRESCRIBER INFORMATION

NAME AND MAILING ADDRESS	APPLICATION DATE YYYY MM DD
	PRESCRIBER'S TELEPHONE # AREA CODE
	PRESCRIBER'S FAX # AREA CODE

SECTION 3 – MEDICATION DETAIL INFORMATION

REQUESTED DRUG (PLEASE PRINT)	DOSAGE AND FREQUENCY

DIAGNOSIS/INDICATION

REASON FOR REQUEST (PLEASE EXPLAIN)

- Contraindication _____
- Adverse Event _____
- Therapeutic Failure _____
- Other _____

OTHER COMMENTS, INCLUDING COPIES OF CULTURE & SENSITIVITY REPORTS FOR ANTIBIOTIC REQUESTS, COPIES OF RELEVANT TEST RESULTS, AND RELEVANT ADVICE RECEIVED FROM CONSULTANTS/SPECIALISTS (IF APPLICABLE)

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under the PEI High-Cost Drugs Program.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

PRESCRIBER SIGNATURE (REQUIRED) **DATE**

11HPE15-30354

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.
APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES.