NUNATSIAVUT
kavamanga Government

HEALTH AND SOCIAL DEVELOPMENT

PROTECTED HIGH
CONTAINS PERSONAL OR SENSITIVE INFORMATION

NON-INSURED HEALTH BENEFITS

PHARMACY SPECIAL AUTHORIZATION REQUEST

Section 1: Beneficiary Information

Name:	Date of Birth:	N Number:

Section 2: Drug Requested For Special Authorization

Product:			DIN:
Request Date:	Duration:	Dosage:	Start/Fill Date:

Section3: Pharmacy Information *(Please Complete)*

Name:	
Address:	
Telephone:	Fax:
Email:	

Section 4: Patient Diagnosis

Section 5: Other Treatments and Medications Tried

Section 6: Reason for Request

◯ Contraindication ◯ Adverse event ◯ Therapeutic failure ◯ Other

Explanation:

Section 7: Physician Information

Name:	Phone Number:	Fax Number:
Address:		
Town/City:	Province:	Postal Code:

Section 8: Requested By

Physician:	Signature:	Date:
Pharmacist:	Signature:	Date:

Section 9: Instructions to Physician

Please complete the section “Drug Requested for Special Authorization”
(explaining why you chose this medication) and sign under “Requested By”.
Please fax completed form to 709-896-9670. Thank you.