SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage for Oseltamivir for Long Term Care Residents

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 Information

Patient Name	**Date of Birth**	**NLPDP Drug Card/MCP Number**

Name of long term care facility/personal care home:

Request for treatment of Influenza A or B

Request for treatment of influenza A or B □ Yes □ No

□ Lab confirmed: Date_____

□ Clinically suspected (meets criteria for ILI & confirmation of influenza A or B in the facility or surrounding community)

Treatment dose (indicate based on patient creatinine clearance):
□ 75mg twice daily for 5 days (CrCl >60ml/min)
□ 75mg once daily for 5 days (CrCl 30-60ml/min)
□ 30mg twice daily for 5 days (CrCl 30-60ml/min)
□ 30mg once daily for 5 days (CrCl 10-30ml/min)
□ Other _____

Request for prophylaxis of Influenza A or B

Has there been an outbreak of influenza A or B in the facility □ Yes □ No

Prophylaxis dose (indicate based on patient creatinine clearance):
□ 75mg once daily (CrCl >60ml/min)
□ 75mg every second day (CrCl 30-60ml/min)
□ 30mg once daily (CrCl 30-60ml/min)
□ 30mg every second day (CrCl 10-30ml/min)
□ Other _____

*14 days prophylaxis coverage will be provided to eligible beneficiaries. Extended coverage can be provided on request if further confirmed cases are identified.

Prescriber:

Prescriber Name: (please print)

License Number:

Address:

Phone Number:

Fax Number:

Signature:

Date: