

Please fax completed form to **506-867-4872** or **1-888-455-8322**.

**Request forms that are missing information will be returned for completion.**

If no mailing address or fax number is provided, we will be unable to return a response.



**Section 1 – Requestor Information**

First Name	
Last Name	
Mailing Address (Street, City, Province, Postal Code)	
Telephone	Fax

**Section 2 – Patient Information**

First Name																		
Last Name																		
Medicare Number (Critical for Processing) <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 15px; height: 15px;">1</td><td style="width: 15px; height: 15px;">2</td><td style="width: 15px; height: 15px;">3</td><td style="width: 15px; height: 15px;">4</td><td style="width: 15px; height: 15px;">5</td><td style="width: 15px; height: 15px;">6</td><td style="width: 15px; height: 15px;">7</td><td style="width: 15px; height: 15px;">8</td><td style="width: 15px; height: 15px;">9</td></tr></table>										1	2	3	4	5	6	7	8	9
1	2	3	4	5	6	7	8	9										
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>									
Date of Birth (DD/MM/YYYY)																		

**Section 3 – Drug Requested**

Requests considered for bupropion tablets or nicotine patches (not both). Select one of the following: Bupropion                      150 mg twice daily. Maximum of 168 additional tablets permitted annually. Nicotine                         Number of patches per day: _____ Anticipated duration of therapy: _____	
---	--

**Section 4 – Therapeutic Information**

<b>Additional Bupropion Tablets</b> i. Individual has a high probability of quitting with additional therapy:    Yes        No ii. Specify number of cigarettes smoked per day prior to initiating bupropion: _____ iii. Specify number of cigarettes currently being smoked per day: _____	
<b>Additional Nicotine Patches (RESTRICTED to those participating in the Ottawa Model)</b> i. Name of hospital, clinic, health center, etc. participating in the Ottawa Model. Please specify: _____ ii. Specify number of cigarettes smoked per day prior to initiating nicotine replacement therapy: _____ iii. Specify number of cigarettes currently being smoked per day: _____	

**Section 5 – Requestor’s Signature**

Signature	License or Registration Number	Date (DD/MM/YYYY)
-----------	--------------------------------	-------------------

This information is collected under the authority of the *Prescription and Catastrophic Drug Insurance Act*, or the *Prescription Drug Payment Act*. This information will be used and disclosed to administer the NB Drug Plans (New Brunswick Prescription Drug Program and New Brunswick Drug Plan). It may be used and disclosed in accordance with the *Personal Health Information Privacy and Access Act*.