

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; text-align: center;">1</td><td style="width: 15px; height: 15px; text-align: center;">2</td><td style="width: 15px; height: 15px; text-align: center;">3</td><td style="width: 15px; height: 15px; text-align: center;">4</td><td style="width: 15px; height: 15px; text-align: center;">5</td><td style="width: 15px; height: 15px; text-align: center;">6</td><td style="width: 15px; height: 15px; text-align: center;">7</td><td style="width: 15px; height: 15px; text-align: center;">8</td><td style="width: 15px; height: 15px; text-align: center;">9</td></tr></table>									1	2	3	4	5	6	7	8	9
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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: _____	
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Section 4 – Therapeutic Information

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

Section 5 – Requestor’s Signature

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