

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
1	2	3	4	5	6	7	8	9										
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>									
Date of Birth (DD/MM/YYYY)																		

Section 3 – Drug Requested

Select one of the following: <input type="checkbox"/> Filgrastim 300 mcg SC daily <input type="checkbox"/> Filgrastim 480 mcg SC daily <input type="checkbox"/> Filgrastim (specify dose): _____ <input type="checkbox"/> Pegfilgrastim 6 mg SC per cycle	Number of cycles required: _____ Number of doses per cycle: _____ OR Anticipated duration of therapy: _____
---	--

Section 4 – Indication

<p>For Chemotherapy Support (Filgrastim or Pegfilgrastim) Chemotherapy is being administered with a curative intent: <input type="checkbox"/> Yes <input type="checkbox"/> No Indication (select one of the following): <input type="checkbox"/> High risk of febrile neutropenia due to chemotherapy regimen, co-morbidities, or pre-existing severe neutropenia <input type="checkbox"/> Febrile neutropenia, neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy <input type="checkbox"/> Chemotherapy dose reduction, or treatment delay greater than one week due to neutropenia <input type="checkbox"/> Other (please specify): _____</p>
<p>For Non-malignant Indications (Filgrastim Only) Indication (select one of the following): <input type="checkbox"/> To increase neutrophil count and reduce the incidence and duration of infection in patients with congenital, idiopathic or cyclic neutropenia <input type="checkbox"/> For the prevention and treatment of neutropenia in patients with HIV infection <input type="checkbox"/> Other (please specify): _____</p>
<p>For Stem Cell Transplantation Support (Filgrastim Only) Indication (select one of the following): <input type="checkbox"/> For mobilization of peripheral blood progenitor cells for the purpose of stem cell transplantation <input type="checkbox"/> To enhance engraftment following stem cell transplantation</p>

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*.