

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 and fax number are provided, we will be unable to return a response.

**For Correctional Services use only**

**Section 1 – Requestor Information**

First Name	
Last Name	
Provincial Correctional Facility (select one) <input type="checkbox"/> Dalhousie Regional Correctional Centre <input type="checkbox"/> Madawaska Regional Correctional Centre <input type="checkbox"/> NB Women's Correctional Centre <input type="checkbox"/> Saint John Regional Correctional Centre <input type="checkbox"/> Southeast Regional Correctional Centre	
Telephone	Fax

**Section 2 – Patient Information**

First Name																		
Last Name																		
Client Information System ID <table border="1"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </table>	1	2	3	4	5	6	7	8	9	<input type="text"/>								
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Medicare Number (if available) <table border="1"> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </table>	<input type="text"/>																	
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Date of Birth (DD/MM/YYYY)																		

**Section 3 – Drug Requested**

<input type="checkbox"/> Bupropion	150 mg twice daily. Maximum of 168 additional tablets permitted annually.
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**Section 4 – Therapeutic Information**

<p><b>Additional Bupropion Tablets</b></p> <p>i. Individual has a high probability of quitting with additional therapy: <input type="checkbox"/> Yes <input type="checkbox"/> 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>
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**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*.