New Brunswick Nouveau Brunswick
New Brunswick Drug Plans / Régimes de médicaments du Nouveau-Brunswick

NEW BRUNSWICK DRUG PLANS
NIRMATRELVIR/RITONAVIR (PAXLOVID)
SPECIAL AUTHORIZATION REQUEST

Request forms **must be completed and retained with the prescription** at the pharmacy.
Please do not fax completed form to the New Brunswick Drug Plans.
Pharmacies must submit claims electronically and include the CPhA intervention code that corresponds to the clinical criteria below.

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 1 2 3 4 5 6 7 8 9 ☐☐☐☐☐☐☐☐☐
Date of Birth (DD/MM/YYYY)

Section 3 – Drug Requested

Drug Name	Dose and Regimen (**maximum 5 days**)
☑ nirmatrelvir/ritonavir (Paxlovid)	

Section 4 – Therapeutic Information

- ❑ Tested positive for COVID-19 and symptoms began in the last 5 days;
  OR
- ❑ A prescription was written for future use. The patient will fill the prescription **only if** they have tested positive for COVID-19 and are within 5 days of symptom onset;

AND is 18 years of age or older, and meets one of the following clinical criteria (select one):

Clinical Criteria	**Intervention Code**
Severely immunosuppressed due to one or more of the following: ❑ Solid organ transplant ❑ Receiving treatment for a malignant hematologic condition ❑ Bone marrow transplant, stem cell transplant or transplant-related immunosuppressant use ❑ Received an anti-CD20 therapy or B-cell depleting therapy (such as rituximab) in the previous two years ❑ Severe primary immunodeficiencies ❑ Other (please specify): ______	**UT**
Moderately immunosuppressed due to one or more of the following: ❑ Receiving treatment for cancer including solid tumors ❑ Receiving treatment with significantly immunosuppressing drugs (e.g., biologic in the past three months, oral immune-suppressing drug in the past month, oral glucocorticoid [20 mg per day of prednisone equivalent taken on an ongoing basis] in the past month, or immune-suppressing infusion or injection in the past three months). ❑ Advanced HIV infection ❑ Moderate primary immunodeficiencies ❑ Renal conditions (i.e., hemodialysis, peritoneal dialysis, glomerulonephritis treated with a glucocorticoid, estimated glomerular filtration rate [eGFR] less than 15 mL/min/1.73 m^2) ❑ Other (please specify): ______	**VE**

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*.