HEALTH CARE PROVIDER FORM

OSTOMY SUPPLIES PROGRAM REGISTRATION

Fax requests to (902) 368-4905, email to drugprograms@gov.pe.ca **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

HIGH COST DRUG PROGRAM PATIENT APPLICATION ALSO REQUIRED PRIOR TO COVERAGE

SECTION 1 – HEALTH CARE PROVIDER INFORMATION

SECTION 2 – PATIENT INFORMATION

NAME AND MAILING ADDRESS	PATIENT (FAMILY NAME)	PATIENT (GIVEN NAME)
	DATE OF BIRTH (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)
PHONE NUMBER (INCLUDE AREA CODE):	PATIENT'S MAILING ADDRESS	
FAX NUMBER (INCLUDE AREA CODE):		
☐ Physician ☐ Nurse Practitioner ☐ NSWOC ☐ Other (Please specify) :		

SECTION 3 – TYPE OF OSTOMY

☐ Temporary
☐ Permanent

☐ Permanent Colostomy
☐ Permanent Ileostomy
☐ Permanent Fecal Continent Reservoir

☐ Permanent Urostomy
☐ Permanent Urinary Continent Reservoir

Date of surgery_____

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under PEI Pharmacare Drug Programs.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

HEALTH CARE PROVIDER SIGNATURE (REQUIRED) **DATE**

MARCH 2024

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.