



**NON-OPIOID Special Authorization Request Form  
Workers' Compensation Board of Nova Scotia**

WCB Claim # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>Mandatory</b>

If the requested medication is an opioid, please complete the opioid form(s) instead.  
Please complete **all** sections clearly and with detail to allow your request to be processed without delay. Use additional pages if necessary. This form must be completed by the prescriber and **submitted to Medavie Blue Cross [Fax (902) 496-5819]**.

<b>Worker Information</b>			
Last Name	First Name	Initial	DOB DD/MM/YYYY
Street	City	Postal Code	HCN

<b>Injury Information</b>
Diagnosis

<b>Treatment Plan</b>			
Requested product name and strength	Directions	Start date	Expected duration

<b>Original request:</b> Contraindication Adverse event Therapeutic failure Other	Explain the expected benefit to recovery of the compensable injury:
<b>Renewal request:</b>	Please outline clinical effectiveness / functional improvement:

Medications tried for this condition ( <b>Mandatory</b> )	Dosage	Duration	Outcome	Ongoing (Y/N)

What non-pharmaceutical therapies have been tried?
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Prescriber's name, address, and fax number  Phone number: _____ Fax number: _____ License # _____ <b>Mandatory</b>	_____ Prescriber's signature	_____ Date DD/MM/YYYY
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Physicians: use MSI fee code **WCB23**. Other prescribers: invoice WCB directly.

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Please return completed form to Medavie Blue Cross or by fax to (902) 496-5819  
PO Box 2200  
Halifax, NS B3J 3C6