The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

Bureau of Health Professions Licensure

Board of Registration in Nursing

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MARYLOU SUDDERS

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MARGRET R. COOKE Acting Commissioner

CHARLES D. BAKER

Governor

KARYN E. POLITO

Lieutenant Governor

**Substance Abuse Rehabilitation Program (SARP)**

#  Prescription Verification Submission Form

Please attach completed release forms for the (1) pharmacy of which you pick up your medications, (2) prescriber, (3) your health care provider (if different from prescriber), and (4) prescription history (PMP) and have your provider send a completed *Prescription Verification and Medical Necessity* form directly to SARP Staff.

**Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Date of Use of Prescription: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Prescription Information

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE OF PRESCRIPTION** | **TYPE OF MEDICATION** | **QUANTITY & DOSAGE PRESCRIBED NUMBER OF****REFILLS** | **RATIONALE FOR MEDICATION** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Licensee’s Signature Date