



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health
 250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
 Governor

KIMBERLEY DRISCOLL
 Lieutenant Governor

KATHLEEN E. WALSH
 Secretary

ROBERT GOLDSTEIN, MD, PhD
 Commissioner

Tel: 617-624-6000
 www.mass.gov/dph

**Substance Addiction Recovery Program (SARP)
 New Prescription Submission Form**

This form is completed when a SARP participant is submitting a new medication for use while participating in SARP. This form is completed by the prescriber and may be submitted by the prescriber or the SARP participant. It may be mailed to the address in the letter head above, or faxed to (617)887-8786.

SARP Participant Name: _____

Prescription Information

Date of Prescription	Name of Medication	Quantity & Dosage	Indication for Medication	Expected Length of Use

I attest that I am aware that the above-named patient is a SARP participant and that the medication(s) listed above is prescribed by me. I am aware that I may need to supply additional documentation regarding my treatment recommendations if the medication(s) listed above is a controlled substance and/or have an addiction potential and/or that may have a higher degree of misuse potential.

Prescriber Name (Please print) Prescriber License Type and Number

Address and Phone Number

Prescriber Signature Signature Date