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)
PRESCRIPTION VERIFICATION AND MEDICAL NECESSITY FORM

This form is completed when a licensee is applying for SARP participation. This form is completed by the prescriber and may be submitted by the prescriber or the SARP applicant. It may be mailed to the address in the letter head or faxed to (617)887-8786.

SARP Applicant Name: _____

Prescription Information

Date of Prescription	Name of Medication	Dose and Quantity	Indication for Medication	Expected Length of Use

I attest that I am aware that the above-named patient is applying for entry into the SARP 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 are 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**

Form Revised January 6, 2023