

Naloxone Request Form Iowa Organizations and Businesses

To help address the issue of opioid misuse, the Iowa Department of Public Health (IDPH) is launching a new initiative to provide naloxone (the opioid overdose reversal medication) to Iowa organizations and businesses which may be in a position to render aid to a person at risk of experiencing an opioid overdose. Funded through the State Opioid Response (SOR 2) grant, IDPH is offering eligible organizations and businesses free naloxone nasal spray kits. The purpose of this initiative is to equip organizations and businesses in the event that their employees, agents, or volunteers encounter someone experiencing a suspected opioid overdose. While the hope is there would never be a need for the use of naloxone, having this medication available as part of a first-aid response could save someone's life.

Eligible organizations and businesses include but are not limited to: retail/convenience stores; libraries; restaurants; bars; community or social-services organizations; event venues; and mobile service providers. Note: Under this grant organizations or businesses which support the use of marijuana to treat substance use or mental health disorders are not eligible.

To complete the process of requesting naloxone kits, an individual with the authority to represent the organization or business must indicate acceptance of the following criteria:

- 1) This organization/business understands the essential components of opioid-related overdose, appropriate overdose response, naloxone storage conditions, and naloxone administration.
- 2) This organization/business shall ensure that any employee, agent, or volunteer authorized to administer naloxone received from the Iowa Department of Public Health has received training on proper naloxone administration.
- 3) This organization/business understands that naloxone provided through this request (1) cannot be distributed or redistributed in any way (including but not limited to being given away, sold, or traded) to anyone outside the organization/business and (2) is intended for use only by employees, agents, or volunteers trained to administer naloxone to an individual whom they reasonably and in good faith believe to be experiencing an opioid-related overdose.
- 4) This organization/business understands that the purpose of this opportunity is to provide naloxone to be used as part of a response to a suspected opioid overdose, only in the event that other policies, laws, licenses or scope of practice do not prohibit this from occurring.
- 5) This organization/business understands that the use of naloxone is not meant to be an alternative to contacting emergency medical services. Due to concerns involving a return of overdose symptoms, always contact 911 when administering naloxone.

A maximum of five (5) naloxone kits per location or per eligible employee, agent, or volunteer, may be requested. If kits are requested for more than one location, please provide a list of the different locations and include the following information:

- Address
- Name of contact person
- E-mail/phone number of contact person
- Number of kits requested

All of the kits requested will be sent to the mailing address listed below.

There are two versions of naloxone offered as part of this initiative, both contain naloxone but have different dosage amounts.

- Narcan Nasal Spray 4 mg
- Kloxxado Nasal Spray 8mg

Please indicate below which version of naloxone is being requested.

By signing this request, I attest that I understand and agree to the criteria specified above and further attest that I have the authority to represent this organization/business. I also understand that my request will be reported to the Iowa Board of Pharmacy but that my name will not be reported to the State's Prescription Drug Monitoring Program (PDMP).

Name of Organization/Business: _____

Type of Organization/Business: _____

Number of Iowa locations: _____

Mailing Address (for naloxone shipment): _____

Website of Organization/Business: _____

Total number of **Narcan** kits requested: _____

Total number of **Kloxxado** kits requested: _____

Printed Name – Organization/Business Representative: _____

Signature – Organization/Business Representative: _____

Date: _____

For IDPH Use Only

AUTHORIZATION

I have reviewed and approve the distribution of naloxone to the above-listed organization or business.

IDPH Program Staff: _____

Date: _____

PRESCRIPTION

I hereby prescribe naloxone in the name of the above-listed representative in the version, strength, and quantity listed in this Naloxone Request Form, which I have reviewed and approved.

Medical Director/Physician Designee of IDPH: _____

Date: _____