SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

Request for Coverage of biologics for Asthma

Pharmaceutical Services
Department of Health and Community Services
P.O. Box 8700, Confederation Bldg.
St. John's, NL A1B 4J6

Phone: (709) 729-6507
Toll Free Line: 1-888-222-0533
Fax: (709) 729-2851

Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number

Address

Drug Requested

☐ Dupixent ☐ Fasenra ☐ Nucala ☐ Tezpire

Diagnosis

☐ Severe Asthma (Tezpire only) ☐ Eosinophilic asthma ☐ Type 2 asthma (Dupixent for patients 6 and over)

Dose and frequency requested:

The requesting physician has experience in the management of patients with asthma: ☐ Yes ☐ No
(e.g. respirologist, clinical immunologist, allergist or internist)

Please provide pre-treatment information for NEW requests for treatment naïve and treatment-experienced patients

For Fasenra, Dupixent, Nucala: Blood eosinophil count:_____ cells/µL) Date:_____

Number* of clinically significant exacerbations of asthma within the 12-month period prior to starting the requested drug (defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized)_____
*Please provide an exact number. If the patient has had no exacerbations, it should be reported as 'zero (0)'.

Pre-treatment Asthma Control Questionnaire (ACQ-5) score (asthma only) _____ Date _____
(please attach a signed and dated copy)

Previous medications utilized: (Check all that apply and include name of medication, dose, duration and response)
☐ Inhaled corticosteroids _____ ☐ Medium-dose (age 6-11 yr) ☐ High-dose
☐ For adults and adolescents aged 12 and older, oral corticosteroids (OCS)_____
☐ Patients require daily maintenance OCS prior to initiation of requested drug? ☐ Yes ☐ No
☐ Other asthma controllers (e.g. long-acting beta-2 agonist, please specify):_____
_____

Complete for RENEWAL requests and INITIAL requests for treatment experienced patients

Number* of clinically significant asthma exacerbations within the previous 12-month period while on the requested drug (defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized):_____
*Please provide an exact number. If the patient has had no exacerbations, it should be reported as 'zero (0)'

Current Asthma Control questionnaire (ACQ-5) score_____ Date:_____
(please attach a signed and dated copy)

For patients requiring daily maintenance OCS prior to initiation of requesting drug ONLY, check if the following applies:
☐ A decrease on the daily maintenance OCS dose from pre-treatment baseline **in the first 12 months of treatment**
☐ The reduction in the daily maintenance OCS dose achieved **after the first 12 months of treatment** has at least been maintained
(Please provide dose details):

Additional Information:

Prescriber Information/Requested: ☐ Physician ☐ Other Healthcare Professional
Prescriber Name: _____ License Number: _____ Phone Number_____
Address: _____ Fax Number:_____
Signature: _____Date:_____
Pharmacist Name: (optional)_____Pharmacy:_____
Signature:_____ Date:_____