SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

Request for Coverage of biologics for Chronic Rhinosinusitis with Nasal Polyps

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

☐ Nucala

Diagnosis

☐ Severe chronic rhinosinusitis with nasal polyps (CRSwNP)

☐ Other (please specify)_____

Nucala will be used as add-on maintenance treatment with intranasal corticosteroids?

☐ YES ☐ NO

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

Patient is inadequately controlled with intranasal corticosteroids and is experiencing refractory symptoms despite use of intranasal corticosteroids for 3 months at maximally tolerated doses Medication (drug, dose, duration, outcome)_____	☐ YES	☐ NO
Patient has endoscopically- or computed tomography-documented bilateral nasal polyps	☐ YES	☐ NO
Patient has undergone at least 1 prior surgical intervention for nasal polyps or has a contraindication to surgery Date of surgery:	☐ YES	☐ NO

*__Pre-treatment scores__

Sino-Nasal Outcome Test (SNOT-22) _____ Assessment date _____ and/or

Endoscopic Nasal Polyps Score (NPS) _____ Assessment date _____

*Requests for patients new to the requested drug, and requests for patients new to coverage but currently maintained on the requested drug, require pre-treatment scores.

Complete for RENEWAL requests and INITIAL requests for treatment experienced patients

Current scores

Sino-Nasal Outcome Test (SNOT-22): _____ Assessment Date: _____ and/or
(SNOT-22 scoresheet should be submitted with request)

Endoscopic Nasal Polyps Score (NPS): _____ Assessment Date: _____

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:_____