# SPECIAL AUTHORIZATION REQUEST FORM
## The Newfoundland and Labrador Prescription Drug Program (NLPDP)
## Request for Coverage for
## HIV Pre-Exposure Prophylaxis

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

□ EMTRICITABINE/TENOFOVIR (Truvada 200mg/300mg and generics)

□ CABOTEGRAVIR (APRETUDE 600mg/3mL VIAL + APRETUDE 30mg tablet which may be used for optional 30 day oral lead-in prior to first IM injection and for oral bridging therapy if person is late for their scheduled injection)

### Criteria

**EMTRICITABINE/TENOFOVIR (Truvada and generics)**

□ For at-risk adult individuals for pre-exposure prophylaxis (PrEP) to reduce the risk of HIV-1 infection.

**CABOTEGRAVIR (APRETUDE 600mg/3mL VIAL)**

□ For at-risk individuals aged 12 years and older and weighing at least 35 kg for pre-exposure prophylaxis (PrEP) to reduce the risk of HIV-1 infection.

**Recent Blood Work:**

**Negative HIV Serology: DD____ MON_____ YYYY_____**
**(4th generation HIV test within past 15 days)**

[ ] I understand that HIV viral load testing is required every 3 months. If negative, a prescription of no more than a three month supply will be issued.

Although NLPDP Special Authorization approvals will be for a 1 year period, prescriptions should only be issued every 3 months after confirmation of a negative HIV test.

**Additional information:**

Prescriber Information / Requested By: □ Physician □ Other Health Professional

Prescriber Name:_____ License Number:_____
(please print)

Address:_____ Phone Number:_____ Fax Number:_____

Signature:_____ Date:_____

Pharmacist Name: (optional)_____ Pharmacy:_____

Name:_____ Date:_____