SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Coverage of Inhalers for Asthma and COPD

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:

Diagnosis of Asthma

Request for Long Acting Beta Agonist (LABA)/Inhaled Steroid (ICS) for Asthma

Select LABA/ICS inhaler/strength:

Advair/generics: ☐ MDI 125/25 ☐ MDI 250/25 ☐ Diskus 100/50 ☐ Diskus 250/50 ☐ Diskus 500/50

Breo Ellipta: ☐ 100/25 ☐ 200/25 Symbicort: ☐ 100/6 ☐ 200/6 Zenhale: ☐ 100/5 ☐ 200/5

Tick ONE of the following: (**minimum 2 month trial**):

☐ Poorly controlled despite optimal trial of ICS inhaler. Symptomatic/requiring increasing doses of short acting beta-agonist.
ICS inhaler/strength: _____ Trial dates: _____

☐ Patient diagnosed with both Asthma and COPD (no need to have a trial of ICS before requesting LABA/ICS)

Request for Enerzair (indacaterol/glycopyrronium/mometasone) for Asthma

☐ Poorly controlled despite minimum 2 months trial of LABA/ICS **AND** experienced ≥ 1 exacerbation in the previous 12 months.

Diagnosis of COPD

Request for Long Acting Beta Agonist (LABA) Monotherapy for COPD

Inhaler requested: ☐ Oxeze 6mcg ☐ Oxeze 12mcg ☐ Serevent Diskus 50mcg

☐ Patient has failed a 2 month trial or is intolerant to LAMA inhaler. LAMA inhaler: _____ Start date: _____

Request for LAMA/LABA dual therapy for COPD

Inhaler requested: ☐ Anoro Ellipta ☐ Duaklir Genuair ☐ Inspiolto Respimat ☐ Ultibro Breezhaler

☐ Moderate to severe COPD (defined as CAT score ≥ 10 or mMRC ≥ 2) CAT score: _____ mMRC score:_____ **OR**

☐ Exacerbation in the previous year on LAMA or LABA. Date(s) of exacerbation(s): _____

Request for Triple Therapy (LAMA/LABA/ICS) for COPD

Inhaler requested: ☐ Trelegy Ellipta 100-62.5-25mcg ☐ Breztri Aerosphere

Tick ONE of the following:

☐ Symptomatic despite a minimum 2 month trial with LAMA/LABA **OR** LABA/ICS: Inhaler:_____ Date Started:_____

☐ Two or more exacerbations of COPD requiring treatment with antibiotics and/or systemic corticosteroids in the last 12 months

☐ At least one exacerbation of COPD in the last 12 months requiring hospitalization or an emergency department visit.

Diagnostic Information (Please attach full PFT report):

FEV1 %:(post bronchodilator):_____ FEV1/FVC: (post bronchodilator):_____

☐ Unable to perform PFTs* (Indicate Reason & Provide mMRC and/or CAT score):_____

☐ PFTs ordered but not immediately available (waitlisted). Provide mMRC and/or CAT score):_____

Requesting Alternate Triple Therapy format where Trelegy or Breztri not appropriate.

Reason Trelegy or Breztri is not appropriate: _____

☐ LABA/ICS inhaler/strength: _____ + LAMA inhaler/strength: _____

☐ LAMA/LABA inhaler/strength: _____ + ICS inhaler/strength: _____

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

Requestor Name (please print):_____ **License Number:**_____
Address:_____ **Phone Number:**_____ **Fax Number:**_____
Signature:_____ **Date:**_____