SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Non-Insulin Anti-Diabetic Agents

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 (Indicate Dose)

DPP-4 INHIBITOR

□ Linagliptin (Trajenta)
Dose:_____

□ Saxagliptin (Onglyza and generics).
Dose:_____

□ Sitagliptin (Januvia & generics)
Dose:_____

COMBINED FORMULATION

□ Linagliptin + metformin (Jentadueto)
Dose:_____

□ Saxagliptin + metformin (Komboglyze)
Dose:_____

□ Sitagliptin + metformin (Janumet & generics)
Dose:_____

□ Sitagliptin + metformin (Janumet XR & generics)
Dose:_____

□ Empagliflozin + metformin (Synjardy)
Dose:_____

SGLT2 INHIBITOR

□ Canagliflozin (Invokana)
Dose:_____

□ Empagliflozin (Jardiance)
Dose:_____

GLP-1 RECEPTOR AGONIST

□ Semaglutide (Ozempic)
Dose:_____

□ Semaglutide (Rybelsus)
Dose:_____

Clinical Information (Coverage criteria is on next page.)

Hemoglobin A1c:_____% **Date:_____**

Current and Past Therapies for Diabetes

Metformin:
Please indicate if metformin was tried for at least 3-6 months
□ Yes Dose:_____Duration (start date):_____(end date):_____
Outcome:_____

No, specify reason _____

Please indicate whether the requested DRUG is being used in combination with other antihyperglycemic agents?
□ Yes, please specify (list other antihyperglycemic medications):_____

_____
□ No

Is patient using insulin? □ Yes □ No

(DPP-4 inhibitors and SGLT-2 inhibitors will not be funded for patients using insulin).

Prescriber Information/Requested: ☐ Physician ☐ Other Healthcare Professional
Prescriber Name: _____ License Number: _____ Phone Number_____
Address: _____Fax Number:_____
Signature: _____Date:_____

Pharmacist Name: (optional)_____ Pharmacy:_____
Signature:_____ Date:_____