# SPECIAL AUTHORIZATION REQUEST FORM
# The Newfoundland and Labrador Prescription Drug Program (NLPDP)
# Request for Coverage for Topical Antipsoriatic Agents

Pharmaceutical Services
Department of Health and Community Services
P.O. Box 8700, Confederation
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Phone: (709) 729-6507
Toll Free Line: 1-888-222-0533
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## Patient Information

| Patient Name | Date of Birth | NLPDP Drug Card/MCP Number |
|---|---|---|
| | | |

**Address**

## Drug Requested for Special Authorization

**For coverage of halobetasol propionate / tazarotene (DUOBRII 0.01% / 0.045% LOTION):**

☐ Initiation (Section A) ☐ Renewal (Section B)

## A - For Initiation

**For improving the signs and symptoms of plaque psoriasis in adult patients with moderate-to-severe plaque psoriasis only if the following two conditions are met (please tick and fill):**

☐ 1. Patients must have a clinical diagnosis of plaque psoriasis with all of the following characteristics:

- An Investigator's Global Assessment (IGA) score of 3 (moderate) or 4 (severe)
  - Please specify IGA score _____
- An area of plaque psoriasis appropriate for topical treatment covering a body surface area (BSA) of 3% to 12%

☐ Please specify BSA _____% (0-100%)

☐ Date assessed:_____

☐ 2. For use in patients whom have not adequately responded to a topical high potency corticosteroid and for whom the addition of a second topical medication would be appropriate.

Please provide details of previous treatments_____
_____

## B - For Renewal

**For continued coverage beyond 12 weeks, the patient must meet the following criteria (please tick and fill):**

☐ The patient has been assessed by the prescriber after the initial 8-12 weeks of therapy to determine response

☐ The prescriber has confirmed, in writing that the patient is a responder as defined as at least two-grade improvement from baseline in IGA score and an IGA score of "clear" or "almost clear" (0 or 1).

- Please specify IGA score: _____

Date assessed: _____

**Additional Comments:**

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

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

Address:_____ Phone Number:_____

Signature:_____ Date:_____

Pharmacist Name:_____Pharmacy Name:_____
(optional) (optional)