



**SPECIAL AUTHORIZATION REQUEST FORM**  
**The Newfoundland and Labrador Prescription Drug Program (NLPDP)**  
**Request for Coverage of RIVAROXABAN(Xarelto)**

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**

<b>Patient Name</b>	<b>Date of Birth</b>	<b>NLPDP Drug Card/MCP Number</b>

**Address**

**Rivaroxaban (Xarelto)**

Dosage: \_\_\_\_\_ Duration: \_\_\_\_\_

**Prophylaxis of venous thromboembolism following:**

Total Hip Replacement (THR) Date of Surgery: \_\_\_\_\_

Total Knee Replacement (TKR) Date of Surgery: \_\_\_\_\_

Coverage is considered for a total of 14 days of treatment. This 14 day period includes treatment provided in hospital.

Date thromboprophylaxis was started in hospital: \_\_\_\_\_

Date of Discharge: \_\_\_\_\_

**Comments:**

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

Prescriber Name: \_\_\_\_\_ License Number: \_\_\_\_\_  
 (please print)

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacist Name: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_  
 (optional) (optional)