



SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Levemir® (insulin detemir)

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
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Address

DOSAGE FORM

- Levemir 100 units/mL Penfill **cartridges**
- Levemir 100 units/mL FlexTouch **pre-filled pen**

COVERAGE CRITERIA

For patients who have been diagnosed with Type 1 or Type 2 diabetes AND

- *who have experienced unexplained nocturnal hypoglycemia at least once a month despite optimal management with insulin glargine **OR***
- *have documented severe or continuing systemic or local allergic reactions to both NPH insulin and insulin glargine **OR***
- *who have experienced unexplained nocturnal hypoglycemia at least once a month despite optimal management with NPH insulin and who have documented severe or continuing systemic or local allergic reactions to insulin glargine*

DIAGNOSTIC INFORMATION

- Patient has had **nocturnal hypoglycemia** (abnormally low blood glucose occurring after bedtime during sleep) with:*
 - NPH insulin*
 - Insulin glargine*

Describe nocturnal hypoglycemia frequency (times per month) and severity:

Describe efforts to optimize insulin dosing to avoid nocturnal hypoglycemia and provide good glycemic control:

- Patient has had documented severe or continuing **systemic or local allergic reaction** to:*
 - NPH Insulin*
 - Insulin glargine*

Describe:

Prescriber Information / Requested By:

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

Address: _____ Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

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