SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Anti-VEGF Therapy for Retinal Diseases

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

☐ **Lucentis® 2.3mg/0.23ml** ☐ **Eylea® 2mg/0.05ml**

Diagnostic Information

Diagnosis:
☐ Neovascular (wet) Age Related Macular Degeneration (AMD)
☐ Visual impairment secondary to diabetic macular edema (DME)
☐ Visual impairment due to macular edema secondary to non-ischemic branch retinal vein occlusion (BRVO)
☐ Visual impairment due to macular edema following central retinal vein occlusion (CRVO)
☐ Other_____

Information required for diagnosis of AMD:
Coverage limited to a maximum of 15 vials used to treat the better seeing affected eye.

Diagnosis confirmed by: ☐ Optical Coherence Tomography ☐ Other_____
Has the condition progressed in the last 3 months? ☐ Yes ☐ No
If so, please specify: ☐ Confirmed by retinal angiography ☐ Confirmed by Optical Coherence Tomography or ☐ recent visual acuity changes
Corrected visual acuity between **6/12** and **6/96**: ☐ Yes ☐ No
Lesion size is less than or equal to **12 disc areas** in its linear dimension ☐ Yes ☐ No
Permanent structural damage to the central fovea ☐ Yes ☐ No

Information required for diagnosis of DME:
Coverage limited to 9 vials.

Hemoglobin A1c:_____% Date:_____
Clinically significant diabetic macular edema where laser photocoagulation is also indicated ☐ Yes ☐ No

NOTE: Hemoglobin A1c older than 3-6 months should not be submitted

Information required for diagnosis of CRVO or BRVO:
☐ **CRVO:** Coverage will be limited to 24 months duration AND not to exceed 12 vials.
☐ **BRVO:** Coverage will be limited to 24 months duration AND not to exceed 10 vials.

Previously treated with a vascular endothelial growth factor (VEG-F) inhibitor: ☐ Yes Drug:_____
☐ No

Additional Comments:

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

Prescriber Name:
(please print) License Number:

Address: Phone Number: Fax Number:

Signature: Date:

Please note that Special Authorization Requests normally take approximately 10 working days to be processed.
Version May 2017 – Replaces previous forms