# SPECIAL AUTHORIZATION REQUEST FORM
## The Newfoundland and Labrador Prescription Drug Program (NLPDP)
## Request for Coverage of
## Novel Oral Anticoagulant (NOAC) for Atrial Fibrillation (AF)

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**

### Dose Requested

☐ Pradaxa® 110mg bid ☐ Xarelto® 15mg once daily ☐ Eliquis® 2.5mg bid

☐ Pradaxa® 150mg bid ☐ Xarelto® 20mg once daily ☐ Eliquis® 5mg bid

**Selected notes regarding dosing in AF (refer to monograph for complete dosing information):**

*Pradaxa® dosing:*
- Usual dose 150mg bid
- Age > 80 years: 110mg bid
- CrCl < 30mL/min: use is contraindicated

*Xarelto® dosing:*
- Usual dose 20mg once daily
- CrCl 30-49mL/min: 15mg daily
- CrCl < 30mL/min: use is contraindicated

*Eliquis® dosing:*
- Usual dose 5mg bid
- For patients with **2** of the following: Age ≥ 80, body weight ≤ 60kg, SCr ≥ 133 micromole/L: 2.5mg bid
- CrCl < 25mL/min: use is contraindicated

### Diagnostic Information

**Diagnosis:**
*Only insured for non-valvular atrial fibrillation (AF) in patients with a $CHADS_2$ score of ≥ 1

☐Non-valvular atrial fibrillation (AF) ☐Other diagnosis:_____

☐ $CHADS_2$ score:_____

**Renal Function Tests:** Tests should be current and completed within the last three months. Renal function should be assessed routinely at least once a year in patients treated with NOAC, or more frequently as needed in clinical situations when it is suspected that renal function could decline or deteriorate rapidly.

Creatinine clearance [CrCl]:_____ mL/min Date:_____

### Medication History

| Drug | Dose | Start Date & End Date | Outcome (i.e. inadequate anticoagulation*, etc) |
|---|---|---|---|
| **Warfarin** | | | |
| **Other** | | | |

***Please provide at least the most recent TWO months of INR testing results AND corresponding warfarin doses in the table below and/or another page**

| Date Tested | INR | Warfarin Dose at Time of Testing |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**If warfarin has not been tried, please indicate the reason why:**
☐**Warfarin contraindicated**_____
☐**Other** _____

### 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 June 2015 – Replaces previous forms**