



SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of anti-TNF for Chronic Plaque Psoriasis

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		Patient Weight (KG)

Medication Information

- Enbrel 50mg ***
 - Initiation – 50mg twice a week for 3 months
 - Maintenance – 50mg weekly
- Remicade *** _____ Mg (5mg/kg) 0, 2, and 6 weeks then every 8 weeks
- Humira 40mg** every two weeks (Coverage will be approved initially for 16 weeks. Can be reassessed for yearly coverage based on patient response).
- Other** _____

* Coverage will be approved initially for 3 months. Can be reassessed for yearly coverage based on patient response.

Diagnostic Information

- Patient has severe debilitating disease.
- Body Surface Area involved _____ %
- Significant Involvement of
 - face
 - hands
 - feet
 - genital region
- PASI (Psoriasis Area Severity Index) score _____
- DLQI (Dermatology Life Quality Index) score _____

Previous Therapy

Therapy	Dose	Duration/Dates	Outcome (if contraindicated give reason)
Methotrexate			
Cyclosporine			
Phototherapy			

Additional Information

Prescriber Information / Requested By:

Dermatologist
 Name: (please print) _____ License Number: _____
 Address: _____ Phone Number: _____ Fax Number: _____
 Signature: _____ Date: _____
 Pharmacist Name: (optional) _____ Pharmacy Name: (optional) _____

Please note that Special Authorization Requests can take up to 10 working days to process.

Version June 2009 – Replaces previous forms