SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of Clopidogrel (Plavix)

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

Intravascular Stents

Please check type of stent inserted: Date of Procedure:_____

- ☐ Bare-Metal Stent (BMS) - 30 days
- ☐ Drug Eluting Stent (DES) - 12 months

Acute Coronary Syndrome (ACS)

- ☐ Combination therapy with ASA in patients with non-ST elevation acute coronary syndrome (unstable angina or non-ST elevation MI) - **90 days** Date of ACS Event: _____

OR

- ☐ High Risk Patients with ACS (check applicable risks below) - **12 months**
  - ☐ more than one episode of documented ACS within a 12 month period Dates of ACS Events: _____ _____
  - ☐ documented complex or extensive CAD e.g. diffuse 3 vessel CAD not amendable to revascularization (Attach report)
  - ☐ documented history of previous stroke, TIA or symptomatic PAD

Long-term monotherapy as an alternative to ASA for secondary prevention in a patient who has had one of the following vascular ischemic events:

- ☐ Ischemic stroke or transient ischemic attack (TIA) **AND**
  - ☐ Experienced a recurrent thrombotic event (stroke, symptoms of TIA) while taking ASA **OR**
  - ☐ Documented severe ASA allergy (manifested by anaphylactic reaction, asthma, or nasal polyps **OR**
  - ☐ GI hemorrhage while on ASA
- ☐ Unstable Angina or Myocardial Infarction or Peripheral Vascular Disease **AND**
  - ☐ Documented severe ASA allergy (manifested by anaphylactic reaction, asthma, or nasal polyps) **OR**
  - ☐ GI hemorrhage while on ASA

Comments:

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

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

Address: _____ Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

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

Please note that Special Authorization Requests normally take approximately 10 working days to be processed.

Version May 2017 – Replaces previous forms