SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

For INITIATION of Coverage of Restricted Rheumatoid Arthritis Medications

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)

Diagnostic / Drug Information

Diagnosis:

☐ Rheumatoid Arthritis ☐ Other ______________________

Approximate year patient was diagnosed, if known: ______________________

Requested Drug Name and Dose:

☐ Leflunomide ☐ Abatacept ☐ Infliximab ☐ Etanercept ☐ Adalimumab

Patient's Past Medication History:

Medication	Dose	Date, Duration and Outcome of Therapy
1. Methotrexate		
2. IM Gold (sodium Aurothiomalate)		
3. Hydroxychloroquine		
4. Azathioprine		
5. Chloroquine		
6. D-penicillamine		
7. Cyclosporine		
8. Leflunomide		
9. Other (Specify)		

List which COMBINATIONS of therapies have been tried:

Drug Combinations (including Doses)	Length of Therapy and Outcome (ie intolerant, not effective, etc.)

Patient's current therapy (List all DMARDs and/or biological RA medications with dosing currently being taken.)

Additional Comments (ie. NSAID trials, BASDAI, ASAS, HAQ as appropriate):

Prescriber Information / Requested By:

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 June 2009 – Replaces previous forms