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

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

☐ **Ticagrelor 90mg twice daily** ☐ **Prasugrel 10mg once daily**

Diagnostic Information

☐	In combination with ASA for patients with ST elevation myocardial infarction (STEMI) or non-ST elevation acute coronary syndrome (NSTEACS) who receive percutaneous coronary intervention (PCI). **Approval period is limited to 1 year post-event.** **Date of Event**:___________________________
☐	For the treatment of patients who have recurrent cardiovascular events (STEMI or NSTEACS), or definite stent thrombosis, while on clopidogrel and ASA therapy. **Approval period: long term.** Note: Definite stent thrombosis, according to the Academic Research Consortium, is a total occlusion originating in or within 5 mm of the stent or is a visible thrombus within the stent or is within 5 mm of the stent in the presence of an acute ischemic clinical syndrome within 48 hours. **Date of Event:**__________________________

Drug Requested

☐ **Ticagrelor 60mg twice daily**

Diagnostic Information

☐	In combination with ASA for patients with a history of STEMI or NSTEACS in the previous 3 years who are at high risk for subsequent cardiovascular events. **Approval Period: up to 3 years.** High risk for subsequent cardiovascular events is defined as age 65 years or older, diabetes, second prior spontaneous myocardial infarction, multivessel coronary artery disease, or chronic renal dysfunction (creatinine clearance <60mL/min). **Date of Event:**__________________________

Comments

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

Prescriber Name:
(Please Print)____License Number:__________________

Address: ____Phone Number:________________

Signature: ____Fax Number:___________________Date:______________

Pharmacist Name: (Optional) Pharmacy Name: (optional)_____________________

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