SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) 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

Diagnostic Information (Please attach full PFT report)

FEV_1 %:(post bronchodilator):_______ FEV_1/FVC: (post bronchodilator):_______ MRC score:_______ CAT score:_______

☐ Unable to perform PFTs: Please explain:____

Hospitalized for severe COPD exacerbation in last 12 mths: ☐ Yes ☐ No

Has had two or more moderate COPD exacerbations in last 12 mths requiring antibiotics/steroids: ☐ Yes ☐ No

☐ ACO (asthma-COPD overlap syndrome). Please provide supporting details (ex. HX of asthma/allergy etc.)____

Inhaler/Regimen request (complete only ONE section below)

Section 1: Request for Long Acting Beta Agonist (LABA) Monotherapy:

☐ Foradil 12mcg ☐ Oxeze 6mcg ☐ Oxeze 12mcg ☐ Serevent Diskus 50mcg

Section 2: Request for Long Acting Muscarinic Antagonist (LAAC) Monotherapy:

☐ Spiriva Respimat 2.5mcg ☐ Spiriva Handihaler 18mcg ☐ Incruse Ellipta 62.5mcg ☐ Seebri Breezhaler 50mcg

☐ Tudorza Genuair 400mcg

Section 3: Request for Long Acting Beta Agonist (LABA)/Inhaled Steroid (ICS) for Asthma/COPD overlap

☐ Advair MDI 125/25 ☐ Advair MDI 250/25 ☐ Breo Ellipta 100/25 ☐ Symbicort Turbuhaler 100ug ☐ Symbicort 200ug

☐ Advair Diskus 100/50 ☐ Advair Diskus 250/50 ☐ Advair Diskus 500/50

Section 4: Request for LAAC/LABA dual therapy: (separate inhalers not considered)

☐ Anoro Ellipta ☐ Duaklir Genuair ☐ Inspiolto Respimat ☐ Ultibro Breezhaler

☐ Has been on a LABA or LAAC for a least 1 month. Inhaler:________________________ Date started:_______________

Section 5: Request for Triple Therapy (ICS/LABA plus LAAC or ICS/LABA/LAAC) :

☐ Advair MDI 125/25 ☐ Advair MDI 250/25 ☐ Breo Ellipta 100/25 ☐ Symbicort Turbuhaler

☐ Advair Diskus 100/50 ☐ Advair Diskus 250/50 ☐ Advair Diskus 500/50 ☐ Trelegy Ellipta 100-62.5-25mcg

☐ Breztri Aerosphere 182 mcg-8.2 mcg-5.8 mcg

LAAC (please specify, if applicable):____

Tick **ONE** of the following:

☐ Symptomatic despite at least 2 mths treatment with LAAC/LABA for COPD: Inhaler:___________ Date Started:_______

☐ Symptomatic despite at least 2 mths treatment with LABA/ICS for ACO: Inhaler:___________ Date Started:_______

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

Prescriber Name: (please print):____

Address:____ License Number:__________________________

Signature: __________________________________Phone Number____________________ Fax Number:_____________

Date:____

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

Version September 2023 – Replaces previous forms