SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Diabetes Mellitus Type 2 High Cardiovascular Risk

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

REQUESTED DRUG NAME and DIAGNOSTIC INFORMATION

☐ **Jardiance (empagliflozin): DM Type 2 High Cardiovascular Risk** **Dose:**_____

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular death in patients with type 2 diabetes mellitus and established cardiovascular disease who have inadequate glycemic control despite an adequate trial of metformin.

☐ Inadequate control on metformin: Dose/Duration:_____

Please provide details of cardiac risk below:

☐ History of myocardial infarction (MI)_____

☐ Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)

☐ Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within 12 months prior to selection

☐ Last episode of unstable angina >2 months prior with confirmed evidence of coronary multi/single vessel disease

☐ History of ischemic or hemorrhagic stroke

☐ Occlusive peripheral artery disease

☐ **Synjardy (empagliflozin/metformin)** **Dose:**_____

For the treatment of type 2 diabetes mellitus in patients with cardiovascular disease who are already stabilized on therapy with empagliflozin and metformin.

Empaglifozin dose:_____Metformin dose:_____

Patients must meet coverage criteria for empagliflozin. Please complete relevant form if patient does not already have NLPDP coverage for empagliflozin.

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

Prescriber Name:
(please print)

Address:_____ License Number: _____

Signature:_____ Phone Number:_____ Fax Number: _____

Please note that Special Authorization Requests normally take approximately 10 working days to be processed.
Version October 2023 – Replaces previous forms