SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage for DUOBRII™
(halobetasol propionate and tazarotene lotion)

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
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Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number

Address

Drug Requested for Special Authorization

For coverage of halobetasol propionate / tazarotene (DUOBRII 0.01% - 0.045% LOTION):

☐ Initiation (Section A) ☐ Renewal (Section B)

A - For Initiation

For improving the signs and symptoms of plaque psoriasis in adult patients with moderate-to-severe plaque psoriasis only if the following two conditions are met (please tick and fill):

☐ 1. Patients must have a clinical diagnosis of plaque psoriasis with all of the following characteristics:
- An Investigator's Global Assessment (IGA) score of 3 (moderate) or 4 (severe)
  - Please specify IGA score ___________
- An area of plaque psoriasis appropriate for topical treatment covering a body surface area (BSA) of 3% to 12%

☐ Please specify BSA _________________%

☐ Date assessed:_______________________________

☐ 2. For use in patients whom have not adequately responded to a topical high potency corticosteroid and for whom the addition of a second topical medication would be appropriate.

Please provide details of previous treatments__________________________:_________________________________

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B - For Renewal

For continued coverage beyond 12 weeks, the patient must meet the following criteria (please tick and fill):

☐ The patient has been assessed by the prescriber after the initial 8-12 weeks of therapy to determine response

☐ The prescriber has confirmed, in writing that the patient is a responder as defined as at least two-grade improvement from baseline in IGA score and an IGA score of "clear" or "almost clear" (0 or 1).
- Please specify IGA score ____

Date assessed ________________________

Additional 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) ____

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