



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

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 _____

DOSAGE FORMS

- Levemir 100 units/MI Penfill **cartridge**
- Levemir 100 units/MI FlexTouch **pre-filled pen**

COVERAGE CRITERIA

1. For the treatment of patients with type 1 or type 2 diabetes who have taken other long acting insulin analogues (insulin glargine and insulin degludec), and have:
 - experienced unexplained nocturnal hypoglycemia at least once a month despite optimal management; or
 - documented severe or continuing systemic or local allergic reaction.
2. For the treatment of pediatric and adolescent patients (under 18 years of age) with type 1 diabetes.
3. For the treatment of pregnant individuals with type 1 or type 2 diabetes requiring insulin.

DIAGNOSTIC CRITERIA

Pediatric and adolescent patient (under 18 years of age) with type 1 diabetes.

Pregnant individual with type 1 or type 2 diabetes requiring insulin.

Patient has taken other long acting insulin analogues (insulin glargine and insulin degludec)

AND

experienced unexplained nocturnal hypoglycemia at least once a month despite optimal management

OR

documented severe or continuing systemic or local allergic reaction.

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 January 2023 – Replaces previous forms