SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Non-Insulin Anti-Diabetic Agents

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 (Indicate Dose)

DPP-4 INHIBITOR

☐ Linagliptin (Trajenta)
Dose:________________

☐ Saxagliptin (Onglyza and generics).
Dose:_______________

☐ Sitagliptin (Januvia & generics)
Dose:______________

COMBINED FORMULATION

☐ Dapagliflozin + metformin (Xigduo & generics)
Dose:_________________

☐ Linagliptin + metformin (Jentadueto)
Dose:__________________

☐ Saxagliptin + metformin (Komboglyze)
Dose:___________________

☐ Sitagliptin + metformin (Janumet & generics)
Dose:____________________

☐ Sitagliptin + metformin (Janumet XR & generics)
Dose:_____________________

☐ Empagliflozin + metformin (Synjardy)
Dose:______________________

SGLT2 INHIBITOR

☐ Canagliflozin (Invokana)
Dose:_________________

☐ Empagliflozin (Jardiance)
Dose:___________________

GLP-1 RECEPTOR AGONIST

☐ Semaglutide (Ozempic)
Dose:______________________

☐ Semaglutide (Rybelsus)
Dose:______________________

Clinical Information (Coverage criteria is on next page.)

Hemoglobin A1c: % **Date:**

Current and Past Therapies for Diabetes (indicate drug, dose, date, duration and outcome):
Please indicate if metformin was used:
☐ YES If yes please indicate if a 6 month trial of metformin was used:
☐YES Dose:___________________
☐NO, please specify reason

☐ NO please specify reason

Please indicate if a sulfonylurea was used:
☐ YES Gliclazide Glyburide Glimepiride (circle one) Dose:_________________
☐ NO please specify reason

☐ Patient is not using insulin.

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 process
Version February 2024 – Replaces previous forms