SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of Ophthalmic VEG-F Inhibitor

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

Address

Drug Requested

☐ **Ranibizumab 2.3 mg/0.23 mL** ☐ **Aflibercept 2mg/0.05ml**

Avastin® (bevacizumab) is listed as <u>open benefit</u> under NLPDP and all new patients requiring intravitreal injections start on this as first line treatment, unless there is an obvious contraindication to its use (see below).
<u>Please specify whether</u>:

1. This patient has the following **contraindication** to use of Avastin®:
   - Allergy or hypersensitivity to bevacizumab (please provide details)
   - Documented acute intra-ocular inflammation or endophthalmitis following intravitreal bevacizumab (see point 3)
2. Patient Deemed very **high risk for thromboembolic event**:
   - Multiple previous events with or without permanent deficits
   - History of recent (within 6 months) thromboembolic event (stroke, myocardial infarction, etc.– provide date)
   - Thromboembolic event during treatment with bevacizumab
3. Documented treatment failure with intravitreal Avastin® **(see below*)**
   - No response (no reduction in central foveal thickness or no improvement in visual acuity) following 3 monthly Avastin® treatments
   - Disease progression (increase in central foveal thickness, decrease in visual acuity or new hemorrhage) despite monthly Avastin® treatments

Diagnostic Information

☐ **<u>Neovascular (wet) Age Related Macular Degeneration (AMD):</u>**

- Diagnosis confirmed by:
  - Optical Coherence Tomography
  - Other _____
- Has this condition progressed in the last 3 months? O YES or O NO
  - If so, please specify: O Confirmed by retinal angiography
    O Confirmed by OCT
    O Recent Visual Acuity Changes
- Corrected Visual Acuity between **6/12** and **6/96**? O YES or O NO
- Lesion size is **≤12 disc areas** in its linear dimension? O YES or O NO
- Permeant structural damage to the central fovea? O YES or O NO

☐ **<u>Visual impairment secondary to diabetic macular edema (DME):</u>**

- Hemoglobin A1C: _____ % Date: _____ (Note: Hemoglobin A1C **older than 3-6 months** should not be submitted)
- Clinically significant DME where laser photocoagulation is also indicated O YES or O NO

☐ **<u>CRVO:</u>** ☐ **<u>BRVO:</u>**

- Previously treated with a vascular endothelial growth factor (VEG-F) inhibitor?
  O YES Drug: _____ Outcome: treatment failure or intolerance O NO

***Provide documented VA and OCT readings below for the treated eye(s). VA and OCT must be reflective of next assessment AFTER injection. Please Attach copy of VA and OCT reports to request also.**

	VA (OD)	VA (OS)	OCT (OD)	OCT (OS)	Date
Baseline (at visit for 1st Avastin injection)					
After Number __ Injection					
After Number __ Injection					
After Number __ Injection					

Prescriber Information / Requested By: ☐ Physician ☐ Other Health Professional
Prescriber Name: _____ License Number: _____
Address: _____ Phone Number: _____ Fax Number:_____
Signature: _____ Date: _____

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

Version November 2023 – Replaces previous forms