



**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**

<b>Patient Name</b>	<b>Date of Birth</b>	<b>NLPDP Drug Card/MCP Number</b>
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**Address**

**REQUESTED DRUG NAME and  
DIAGNOSTIC INFORMATION**

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

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 glycemc 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)**

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

Empagliflozin 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 Nov 2019 – Replaces previous forms**