SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage of Novel Oral Anticoagulant (NOAC) for Atrial Fibrillation (AF)

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

Dose Requested and selected notes regarding dosing in AF (see monograph for dosing formation):

☐ **Pradaxa 110mg bid** ☐ **Pradaxa 150mg bid**	**- Usual dose 150mg bid** **- Age > 80 years: 110mg bid** **- CrCl < 30mL/min: use is contraindicated**
☐ **Xarelto 15mg once daily** ☐ **Xarelto 20mg once daily**	**- Usual dose 20mg once daily** **- CrCl 30-49mL/min: 15mg daily** **- CrCl < 30mL/min: use is contraindicated**
☐ **Eliquis 2.5mg bid** ☐ **Eliquis 5mg bid**	**- Usual dose 5mg bid** **- For patients with 2 of the following: Age ≥ 80, body weight ≤ 60kg, SCr ≥ 133 micromole/L: 2.5mg bid** **- CrCl < 25mL/min: use is contraindicated**
☐ **Lixiana 30mg once daily** ☐ **Lixiana 60mg once daily**	**-Usual dose 60mg once daily** **- 30mg once daily if either wt ≤ 60kg, CrCl 30-50 ml/min or concomitant use of some P-gp inhibitors, except amiodarone and verapamil**

Diagnostic Information

Diagnosis:
*Only insured for non-valvular atrial fibrillation (AF) in patients with a $CHADS_2$ score of ≥ 1
☐ Non-valvular atrial fibrillation (AF) ☐ Other diagnosis:________________ ☐ CHADS2 score:________

Renal Function Tests: Tests should be current and completed within the last three months.
Creatinine clearance [CrCl]:______ mL/min Date:_______

Medication History

Drug	Dose	Start Date & End Date	Outcome (i.e. inadequate anticoagulation*, etc)
Warfarin			
Other			

***Please provide at least the most recent TWO months of INR testing results AND corresponding warfarin doses in the table below and/or another page**

Date Tested	INR	Warfarin Dose at Time of Testing

If warfarin has not been tried, please indicate the reason why:
☐ **Warfarin contraindicated**____
☐ **Other** ____

Prescriber Information / Requested By: ☐ Physician ☐ Other Health Professional

Prescriber Name:
(please print) License Number:

Address: Phone Number: Fax Number:

Signature: Date:

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