SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

Request for Continuation of Restricted Rheumatoid Arthritis Medications

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
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Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number

Address	Patient Weight (kg)

REQUEST FOR CONTINUATION OF COVERAGE

Drug Name and Dosage:

Please indicate level of patient response: (*e.g. utilizing symptoms, joint counts & relative laboratory data)*

- ❑ ACR < 20%
- ❑ ACR 20%
- ❑ ACR 50%
- ❑ ACR 70%

Side effects related to therapy:

Additional Comments:

Physician's Name & Address	_____ Signature	_____ Date

Criteria for Leflunamide, Etanercept, Adalimumab and Infliximab

Leflunomide can be approved for patients with a diagnosis of active rheumatoid arthritis (RA) who

- have not responded or who have had intolerable toxicity to an adequate trial of combination therapy of at least two traditional DMARDs† or
- if combination therapy is not an option, an adequate trial of at least three traditional DMARDs in sequence as monotherapy.
- Therapy must include methotrexate ‡ alone or in combination unless contraindicated or not tolerated

Inflixmab, Adalimumab and **Entanercept** can be approved in patients with a diagnosis of active rheumatoid arthritis *(RA)* as per the above criteria for leflunomide, **except patients must also have had an adequate trial of leflunomide, unless contraindicated or not tolerated.**
Coverage for these Rheumatoid Arthritis Drugs will be approved initially for 6 months and can be reassessed for yearly coverage dependent on patient achieving an improvement in symptoms of at least 20%

*An adequate trial is 5 months for IM gold, 6 months for D-penicillamine, 4 months for hydroxychloroquine, and 3 months for all other traditional DMARDs as well as Leflunomide, Etanercept and Infliximab.
† Traditional agents include MTZ, IM gold, sulfasalazine, hydroxychloroquine, azathioprine, chloroquin, D-penicillamine, and cyclosporin.
‡ Unless limited by toxicity, MTZ dosage should be increased up to 25mg/wk unless response is achieved at lower dose.

***Please note that Special Authorization Requests can take up to 10 working days to process.**

Version February 2007 – Replaces previous forms