

Fax requests to (902) 368-4905 OR mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – PRESCRIBER INFORMATION

SECTION 2 – PATIENT INFORMATION

NAME AND MAILING ADDRESS	PATIENT (FAMILY NAME)	PATIENT (GIVEN NAME)
	DATE OF BIRTH (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)
PHONE NUMBER (INCLUDE AREA CODE):	PATIENT'S MAILING ADDRESS	
FAX NUMBER (INCLUDE AREA CODE):		

SECTION 3 – MEDICATION AND DOSE SELECTION

<input type="checkbox"/> CANAgliflozin (Invokana)	<input type="checkbox"/> EMPAgliflozin (Jardiance)	<input type="checkbox"/> LINAgliptin + metformin (Jentaduetto)	<input type="checkbox"/> SAXAgliptin + metformin (Komboglyze)	<input type="checkbox"/> SITAgliptin + metformin (Janumet)
<input type="checkbox"/> DAPAgliflozin (Forxiga)	<input type="checkbox"/> LINAgliptin (Trajenta)	<input type="checkbox"/> SAXAgliptin (Onglyza)	<input type="checkbox"/> SITAgliptin (Januvia)	<input type="checkbox"/> SITAgliptin + metformin (Janumet XR)

CRITERIA FOR COVERAGE

As add-on therapy for the treatment of Type 2 diabetes in patients with intolerance to and/or inadequate glycemic control on:

- a sufficient trial (i.e. a minimum of 6 months) of metformin, **AND**
 - a sulfonylurea, **AND**
 - for whom insulin is not an option.
 - are already stabilized on a DPP-4 inhibitor + metformin and want to replace the individual components
- Or, for whom these products are contraindicated.**

Please indicate if metformin was used:

YES

If yes please indicate if a 6 month trial of metformin was used:

YES

NO, please specify reason

NO, please specify reason

Please indicate if a sulfonylurea was used:

YES

NO, please specify reason

Please indicate why insulin is not an option for this patient:

Manual dexterity concerns

Cognitive impairment

Visual impairment

Other, please specify

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under the PEI Diabetes Drug Program.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

PRESCRIBER SIGNATURE (REQUIRED)

DATE