Health PEI

SPECIAL AUTHORIZATION REQUEST

DPP-4/SGLT2 INHIBITORS

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):		

Criteria 1: Add-on therapy

☐ CANAgliflozin **(Invokana®)**	☐ DAPAgliflozin **(Forxiga®)**	☐ DAPAgliflozin + metformin **(Xigduo®)**	☐ EMPAgliflozin **(Jardiance®)**	☐ EMPAgliflozin + metformin **(Synjardy®)**
☐ LINAgliptin **(Trajenta®)**	☐ LINAgliptin + metformin **(Jentadueto®)**	☐ SAXAgliptin **(Onglyza®)**	☐ SAXAgliptin + metformin **(Komboglyze®)**	☐ SITAgliptin **(Januvia®)**
☐ SITAgliptin + metformin **(Janumet®)**	☐ SITAgliptin + metformin **(Janumet XR®)**			

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 or SGLT2 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

See page 2 for secondary prevention criteria

Criteria 2: Secondary prevention

☐ EMPAgliflozin **(Jardiance®)**
☐ EMPAgliflozin/metformin **(Synjardy®)** if already approved for EMPAgliflozin and stabilized on individual components

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with Type 2 diabetes mellitus and established cardiovascular disease, who have inadequate glycemic control despite a sufficient trial of metformin.

Please indicate if a 6 month trial of metformin was used:

☐ YES

☐ NO, please specify reason

Please indicate element(s) of established cardiovascular disease:

☐ 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

☐ Last episode of unstable angina >2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease

☐ History of ischemic or hemorrhagic stroke

☐ Occlusive peripheral artery disease

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**

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.
APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES