

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

<input type="checkbox"/> CANAgli flozin ( <b>Invokana</b> ®)	<input type="checkbox"/> DAPAgli flozin ( <b>Forxiga</b> ®)	<input type="checkbox"/> DAPAgli flozin + metformin ( <b>Xigduo</b> ®)	<input type="checkbox"/> EMPAgli flozin ( <b>Jardiance</b> ®)	<input type="checkbox"/> EMPAgli flozin + metformin ( <b>Synjardy</b> ®)
<input type="checkbox"/> LINAgliptin ( <b>Trajenta</b> ®)	<input type="checkbox"/> LINAgliptin + metformin ( <b>Jentaduo</b> ®)	<input type="checkbox"/> SAXAgliptin ( <b>Onglyza</b> ®)	<input type="checkbox"/> SAXAgliptin + metformin ( <b>Komboglyze</b> ®)	<input type="checkbox"/> SITAgliptin ( <b>Januvia</b> ®)
<input type="checkbox"/> SITAgliptin + metformin ( <b>Janumet</b> ®)	<input type="checkbox"/> SITAgliptin + metformin ( <b>Janumet XR</b> ®)			

**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

## Criteria 2: Secondary prevention

- EMPAgliflozin (**Jardiance**<sup>®</sup>)
- EMPAgliflozin/metformin (**Synjardy**<sup>®</sup>) 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

Special Authorization grants coverage to a drug that otherwise would not be eligible for coverage. Coverage is provided to patients in specific medical circumstances as defined in the PEI Pharmacare Formulary and **subject to Pharmacare Drug Program plan rules, including deductible and eligibility requirements.**

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

Nov 2022 JC