Print Form

Health PEI

# SPECIAL AUTHORIZATION REQUEST

# IDIOPATHIC PULMONARY FIBROSIS

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

☐ **INITIAL REQUEST** ☐ **RENEWAL REQUEST (skip to renewal request section)**

**MEDICATION AND DOSE REQUESTED:**

## SECTION 4 – BACKGROUND DIAGNOSTIC INFORMATION

**DIAGNOSIS**

☐ Idiopathic Pulmonary Fibrosis (IPF)

IPF confirmed by HRCT scan? YES ☐ NO ☐

**PULMONARY FUNCTION TEST (PFT)**

Forced Vital Capacity (FVC) % predicted _____%  Date measured_____

## SECTION 5 – RENEWAL REQUEST

Has the FVC percent predicted declined by ≥ 10% since initiation of therapy: **YES** ☐ **NO** ☐

- If **NO** please provide result of most recent FVC percent predicted _____% Date measured _____
- If **YES** please provide result of confirmatory PFT conducted 4 weeks after decrease in FVC:
  Confirmatory FVC% predicted_____%

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 High-Cost Drugs 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.**