SPECIAL AUTHORIZATION REQUEST

LONG ACTING INSULIN ANALOGUES

Fax requests to (902) 368-4905, email to drugprograms@gov.pe.ca **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)		PATIENT (FAMILY) NAME	PATIENT (GIVEN) NAME(S)
DATE OF BIRTH (YYYY/MM/DD)	PATIENT WEIGHT (kg)	PATIENT'S MAILING ADDRESS	

SECTION 2 – PRESCRIBER INFORMATION

NAME AND MAILING ADDRESS	APPLICATION DATE YYYY MM DD
	PRESCRIBER'S TELEPHONE # AREA CODE
	PRESCRIBER'S FAX # AREA CODE

SECTION 3 – MEDICATION DETAIL INFORMATION

REGUESTED DRUG

☐ Lantus® (Insulin Glargine) **Criteria 1 or 2**

☐ Levemir® (Insulin Detemir) **Criteria 1 or 2**

☐ Toujeo® (Insulin Glargine) **Criteria 1, 2, or 3**

Patients must meet the following criteria for special authorization:

For the treatment of patients who have been diagnosed with type 1 or type 2 diabetes requiring insulin and have **previously taken all open benefit long acting insulin analogues** daily at optimal dosing **AND**

- have experienced unexplained **nocturnal hypoglycemia** at least once a month despite optimal management

  OR

- have documented severe or continuing systemic or local **allergic reaction** to existing insulin(s)

DIAGNOSIS

☐ Type 1 diabetes ☐ Type 2 diabetes

LONG ACTING INSULIN ANALOGUES TRIED:

☐ Yes ☐ No

CLINICAL CRITERIA: REASON FOR REQUEST (PLEASE EXPLAIN)

1. ☐ **Nocturnal hypoglycemia**

Please describe frequency and severity of nocturnal hypoglycemia:

OR

2. ☐ **Allergic reaction**

Please describe continuing systemic or local allergic reaction to existing insulin (s)

OR

3. ☐ **Requires high dose insulin (for Toujeo requests only).** Please indicate required dose_____

OTHER COMMENTS (IF APPLICABLE)

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 Pharmacare Drug Programs.

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**

March 2024-CM

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