Health PEI
One Island Health System

SPECIAL AUTHORIZATION REQUEST

LOW MOLECULAR WEIGHT HEPARIN

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

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)		PATIENT (FAMILY) NAME
DATE OF BIRTH (YYYY/MM/DD)	PATIENT WEIGHT (kg)	PATIENT (GIVEN) NAME(S)
PATIENT'S TELEPHONE # AREA CODE	PATIENT 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

REQUESTED DRUG (PLEASE CHECK ONE) ☐ **Dalteparin (Fragmin)** ☐ **Enoxaparin (Lovenox)** ☐ **Tinzaparin (Innohep)**	DOSAGE AND FREQUENCY

TREATMENT OR PROPHYLAXIS CRITERIA (check relevant boxes below):

☐ For the acute treatment of deep vein thrombosis (DVT) and/or pulmonary embolism (PE) for a maximum of 30 days;

☐ For prophylaxis in hip replacement and hip fracture surgery; approval is limited to a maximum of 35 days;

☐ For prophylaxis in knee replacement surgery; approval is limited to a maximum of 10 days;

☐ For prophylaxis in high-risk surgery; approval is limited to a maximum of 10 days.

☐ For the extended treatment of recurrent symptomatic venous thromboembolism (VTE) that has occurred while patients are on therapeutic doses of warfarin

☐ For the treatment and secondary prevention of symptomatic venous thromboembolism (VTE) or pulmonary embolism (PE) for a period of up to 6 months in patients with cancer

The PEI Drug Programs 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.