

## **SPECIAL AUTHORIZATION REQUEST**

## **RETINAL DISEASE TREATMENT**

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

HIGH COST DRUG PROGRAM PATIENT APPLICATION ALSO REQUIRED PRIOR TO COVERAGE

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 – DIAGNOSIS, INDICATION AND MEDICATION		
Neovascular (wet) age-related macular degeneration Aflibercept Brolucizumab Ranibizumab  BCVA score		
Diabetic macular edema (DME)		
Retinal vein occlusion (RVO) Aflibercept Ranibizumab Central Retinal vein occlusion (CRVO) Branch Retinal vein occlusion (BRVO) Maximum 12 months coverage		
Choroidal neovascularization (CNV)  Maximum 12 months coverage  Ranibizumab		
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 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