Ontario

Ministry of Health and Long-Term Care

Drug Programs Branch
Individual Clinical Review (Section 8)
3rd floor, 5700 Yonge St.
Toronto ON M2M 4K5

Request for an Unlisted Oral Antidiabetic Drug for Type 2 Diabetes
Individual Clinical Review (Section 8)

Please fax completed form to (416) 327–7526 or toll–free 1 866 811–9908 or mail to the above address. (Do not mail if request is faxed).

The Ministry of Health and Long-Term Care (the "Ministry") considers requests for coverage of drug products not listed in the Ontario Drug Benefit Formulary under Section 8 of the *Ontario Drug Benefit Act*, R.S.O. 1990 c. O.10 (Individual Clinical Review). This form is intended to facilitate requests for an unlisted oral antidiabetic drug for Type 2 Diabetes. The ministry may request additional documentation to support the request. Please ensure that all appropriate information for each section is provided to avoid delays.

Section 1 – Prescriber Information

First name | Last name

Mailing address
Street no. | Street name

City | Postal code

Fax no. ( )

Telephone no. ( )

Section 2 – Patient Information

First name | Last name

Date of birth

Health Number

Section 3 – Drug Requested

Name of drug	Tablet strength requested			Dosage (dose, frequency)
Actos (pioglitazone)	☐ 15 mg	☐ 30 mg	☐ 45 mg	
Avandia (rosiglitazone)	☐ 2 mg	☐ 4 mg	☐ 8 mg	
Diamicron (gliclazide)	☐ 30 mg MR	☐ 80 mg		
Gluconorm (repaglinide)	☐ 0.5 mg	☐ 1 mg	☐ 2 mg	
Starlix (nateglinide)	☐ 60 mg	☐ 120 mg	☐ 180 mg	

Section 4 – Clinical Information *(attach an additional sheet to provide other relevant information or if more space is required)*

The drug is being requested to treat Type 2 diabetes ☐ yes ☐ no *(specify reason below)*

The following Formulary alternatives (glyburide ***and*** metformin) were adequately tried at maximal doses and glycemic levels remained uncontrolled, or were not tolerated or contraindicated. *For renewals, please include all current relevant therapy. If intolerance or contraindication, please include details.*

Name of drug	Dose	Frequency	Duration	Other details
1. **Glyburide** ☐ current therapy ☐ previous therapy				*(if max dose 20mg/day not tried, indicate reason)*
2. **Metformin** ☐ current therapy ☐ previous therapy				*(if max dose 2000mg/day not tried, indicate reason)*
3. ☐ current therapy ☐ previous therapy				
4. ☐ current therapy ☐ previous therapy				

The following is the most recent lab result *(please provide at least one result, HbA1c preferred):*

	Date of lab result	Level	If HbA1c level not provided, indicate reason
HbA1c			
Fasting blood sugar			

Initial requests

☐ If HbA1c $\leq$ 0.07, provide reason for starting therapy:

Renewal requests *(indicate patient's response to therapy)*

☐ Patient has been on requested drug for two or more years and glycemic levels have remained stable

☐ HbA1c level improved by $\geq$ 0.005

☐ HbA1c level not improved by $\geq$ 0.005 *(indicate rationale for continued therapy)*

The information on this form is collected by the Ministry of Health and Long-Term Care under the authority of s.13 of the *Ontario Drug Benefit Act* R.S.O. 1990 c. O.10. The information is collected for the purpose of considering whether special coverage of an unlisted drug should be approved under section 8 of the *Ontario Drug Benefit Act*, and will be used and disclosed for this purpose. It may also be used and disclosed for the administration of the Ontario Drug Benefit program. If you have any questions about the collection of this information, call the Ontario Drug Programs Help Desk at 1 800 668–6641 or contact the Director, Drug Programs Branch, 5700 Yonge St., 3rd Floor, Toronto ON M2M 4K5.

Prescriber signature | CPSO number | Date