Nova Scotia Provincial Pharmacare Programs

Request for Coverage of Restricted Systemic Agents for Atopic Dermatitis

PATIENT INFORMATION			
PATIENT SURNAME	**PATIENT GIVEN NAME**	**HEALTH CARD NUMBER**	**DATE OF BIRTH**
PATIENT ADDRESS			

REQUEST FOR INITIAL COVERAGE

Requested Agent:

☐ Abrocitinib ☐ Dupilumab

Diagnosis:

For the treatment of moderate to severe atopic dermatitis in patients 12 years of age and older, who meet **ALL** of the following criteria:

1. ☐ Baseline Physician Global Assessment score ≥ 3 and Eczema Area and Severity Index (EASI) score of ≥ 7.1
   Baseline Physician Global Assessment Score: _____ Date: _____ EASI Score: _____ Date:_____

Patient's Past Medication History:

2. ☐ Had an adequate trial (with a documented refractory disease), or were intolerant (with documented intolerance), or are ineligible for each of the following therapies **(Please provide details below):**

   ☐ Maximally tolerated medical topical therapies for AD combined with phototherapy (where available), **and**;

   ☐ Maximally tolerated medical topical therapies for AD combined with at least 1 of the 4 systemic immunomodulators (methotrexate, cyclosporine, mycophenolate mofetil, or azathioprine).

3. Agents tried: Length of therapy, outcome (i.e., not effective or details of intolerance); if contraindicated (provide details)

- ☐ Medical topical therapies _____
- ☐ Phototherapy _____
- ☐ Methotrexate _____
- ☐ Cyclosporine _____
- ☐ Mycophenolate mofetil _____
- ☐ Azathioprine _____

REQUEST FOR COVERAGE RENEWAL

Initial Renewal request:

Beneficial clinical effect, defined as a 75% or greater improvement from baseline in the EASI score (EASI-75) six months after treatment initiation.

Eczema Area and Severity Index score: _____ Date: _____

Subsequent Renewal Requests:

Maintenance of EASI-75 response from baseline

Eczema Area and Severity Index score: _____ Date: _____

PRESCRIBER NAME & ADDRESS:		
LICENCE #	**PRESCRIBER SIGNATURE**	**DATE**

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1, Fax: (902) 496-4440

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