

**Nova Scotia Provincial Pharmacare Programs**  
**Request for Coverage of Injectable Vitamin B<sub>12</sub>**

PATIENT INFORMATION			
PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
PATIENT ADDRESS			
DIAGNOSTIC INFORMATION			
<p><b>Please provide the following information if you wish to request insured coverage of the injectable Vitamin B<sub>12</sub>. Requests will be considered only if oral products are not an option for the above patient.</b></p> <p><b>1. Initiation of Vitamin B<sub>12</sub> therapy for this patient was based on:</b></p> <p><input type="checkbox"/> Subnormal Vitamin B<sub>12</sub> levels, confirmed by laboratory report.</p> <p><input type="checkbox"/> Clinical symptoms of deficiency</p> <p><input type="checkbox"/> Other – Please explain: _____</p> <p>_____</p> <p><b>2. Please indicate reason why IM route is necessary:</b></p> <p><input type="checkbox"/> Severe neurological symptoms</p> <p><input type="checkbox"/> Unable to swallow tablets</p> <p><input type="checkbox"/> Poorly functioning or resected ileum</p> <p><input type="checkbox"/> Other – Please explain: _____</p> <p>_____</p>			
<p><b>Additional Comments:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>			
<b>PRESCRIBER NAME &amp; ADDRESS:</b>			
_____ 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) 468-9402