Nova Scotia Provincial Pharmacare Programs

Request for Coverage of Mayzent (siponimod)

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

INITIAL REQUEST

1. For the treatment of patients with active secondary progressive multiple sclerosis, who meet **ALL** the following criteria:

☐ A history of relapsing-remitting multiple sclerosis (RRMS)

☐ An Expanded Disability Status Scale (EDSS) score of 3.0 to 6.5

Current EDSS score: _______________ Date: _______________

☐ Documented EDSS progression during the two years prior to initiating treatment with siponimod (≥ 1 point if EDSS < 6.0; ≥ 0.5 points if EDSS ≥ 6.0 at screening).

EDSS score two years prior to initiating siponimod treatment: _______________ Date: _______________

2. Start date of siponimod (if applicable)*: _______________

3. Baseline timed 25-foot walk (T25W) has been completed prior to siponimod initiation. ☐ Yes ☐ No

RENEWAL REQUEST

For patients who do **NOT** exhibit evidence of disease progression since the previous assessment.

1. Has the patient experienced an increase in the EDSS score of greater than or equal to 1 point if the EDSS score was 3.0 to 5.0 at siponimod initiation? ☐ Yes ☐ No

2. Has the patient experienced an increase of greater than or equal to 0.5 points if the EDSS score was 5.5 to 6.5 at siponimod initiation? ☐ Yes ☐ No

3. Has the patient experienced progression to an EDSS score of equal to or greater than 7.0 at any time during siponimod treatment? ☐ Yes ☐ No

4. Has the patient experienced confirmed worsening of at least 20% on the timed 25-foot walk (T25W) since initiating siponimod treatment? ☐ Yes ☐ No

Current EDSS 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