Nova Scotia Provincial Pharmacare Programs

Request for Coverage of Rituximab

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

DIAGNOSTIC / DRUG INFORMATION

DIAGNOSIS / INDICATION:

☐ Rheumatoid Arthritis ☐ GPA/MPA ☐ Other Autoimmune Disorders/Other Conditions _____

MEDICATION HISTORY:

Request for Rheumatoid Arthritis:

☐ Failed to respond to an adequate trial of an anti-TNF agent. Please provide details below:

Drug name, duration, and outcome: _____

_____

☐ Severe intolerance or other contraindication to a trial of an anti-TNF agent. Please provide details below:

_____

_____

Request for GPA/MPA:

☐ Severe intolerance or other contraindication to cyclophosphamide, or has failed an adequate trial of cyclophosphamide

Please provide further details regarding intolerance/contraindication: _____

_____

Request for Other Autoimmune Disorders/Other Conditions:

Please provide details of other treatments tried, including drug name, dose, duration, and outcome. (Should you require more space, please attach additional pages to the application and include patient identifiers.)

_____

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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

09/2023

NOVA SCOTIA