Nova Scotia Provincial Pharmacare Programs

Request for Coverage of Verkazia (cyclosporine) Ophthalmic Emulsion

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

REQUEST TYPE

☐ First Request (complete Section 1) ☐ Renewal/Re-initiation Request (complete Sections 1 and 2)

SECTION 1: ALL REQUESTS

☐ **For the treatment of pediatric patients between the age of 4 and 18 years of age with severe vernal keratoconjunctivitis (VKC) who meet the following criteria:**

- ☐ Grade 3 (severe) or 4 (very severe) on the Bonini scale, **OR**
- ☐ Grade 4 (marked) or 5 (severe) on the modified Oxford scale

☐ **Patient is under the care of a physician experienced in the diagnosis and management of VKC**.

☐ **Please provide details of the severity of signs and symptoms of VKC:**

_____

_____

_____

SECTION 2: TREATMENT RENEWAL/RE-INITIATION

Has there been an improvement in signs and symptoms of VKC? ☐ Yes ☐ No

Have the signs and symptoms of VKC resolved? ☐ Yes ☐ No

☐ Patient was previously treated with cyclosporine 0.1% but discontinued treatment upon resolution of VKC signs and symptoms and the signs and symptoms of severe VKC have recurred.

OTHER COMMENTS (if applicable):

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

NOVA SCOTIA