

Nova Scotia Provincial Pharmacare Programs
Request for Coverage of Parenteral Iron Products

PATIENT INFORMATION			
PATIENT'S SURNAME	PATIENT'S GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
PATIENT'S ADDRESS			
DIAGNOSTIC INFORMATION			
DIAGNOSIS: <input type="checkbox"/> Iron-deficiency anemia			
DRUG REQUESTED			
<input type="checkbox"/> Saccharated iron oxide (iron sucrose, Venofer®) <input type="checkbox"/> Sodium Ferric Gluconate (Ferrlecit®) <input type="checkbox"/> Ferric Derisomaltose (Monoferric®)			
REASON FOR REQUEST: <input type="checkbox"/> Intolerant to oral iron replacement products. Describe intolerance: _____ <input type="checkbox"/> Has not responded to adequate therapy with oral iron. Dose/duration/outcome: _____ <input type="checkbox"/> Patient requires IV iron for anemia management of chronic kidney disease and is (check one that applies): <input type="checkbox"/> Receiving hemodialysis <input type="checkbox"/> Receiving peritoneal dialysis – describe oral iron trial: _____ <input type="checkbox"/> Predialysis – describe oral iron trial: _____			
OTHER COMMENTS (if applicable): 			
PRESCRIBER'S 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