NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
Request for Coverage of Sevelamer and Sucroferric Oxyhydroxide (Velphoro)

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

DRUG REQUESTED AND DOSAGE

☐ **Sevelamer** Dosage: _____

☐ **Sucroferric Oxyhydroxide (Velphoro)** Dosage: _____

REQUEST FOR COVERAGE

☐ **Initial Request for 6 Months**

Initial phosphate level = _____ mmol/L

► Check all that apply

- ☐ eGFR ≤ 15mL/min
  AND
- ☐ Inadequate control of phosphate levels on a calcium-based phosphate binder, **OR**
- ☐ Hypercalcemia, **OR**
- ☐ Calciphylaxis

☐ **Renewal Request for 1 Year**

Current phosphate level = _____ mmol/L

► If patient is not sufficiently responding, but continuation of therapy is being requested, please explain why (e.g., working on a diet, compliance, etc.):

_____

_____

_____

Additional Comments:

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

10/2020

NOVA SCOTIA