NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Systemic Agents for Asthma

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

REQUESTED DRUG

☐ Benralizumab (Fasenra) ☐ Mepolizumab (Nucala) ☐ Tezepelumab (Tezspire) ☐ Dupilumab (Dupixent)

Start date: _____

Please note: If the patient is established on the above requested therapy at the time of the initial request for coverage, please complete the Initial Request and Renewal Request sections below.

INITIAL REQUEST

DIAGNOSIS

Benralizumab or Mepolizumab (Adult patients):	Tezepelumab (Patients 12 years and older):	Dupilumab*:
☐ Severe eosinophilic asthma	☐ Severe asthma	☐ Severe asthma with a type 2 or eosinophilic phenotype **(patients 6 years of age and older) OR** ☐ Oral corticosteroid (OCS) dependent severe asthma **(patients 12 years of age and older)** * Please refer to age-specific criteria

BASELINE INFORMATION

1.) Inadequate response to the following medications:

☐ Inhaled corticosteroid: _____ Dose:_____ ☐ High-dose[1] ☐ Medium-dose[2] Duration: _____

☐ One or more additional asthma controller(s) (e.g., long-acting beta-agonist). Please specify: _____ Duration: _____

1. High-dose inhaled corticosteroids is defined as greater than or equal to 500 mcg of fluticasone propionate or equivalent daily dose.
2. **Dupilumab patients aged 6 to 11 years of age:** Medium dose ICS is defined as between 200 mcg and 400 mcg of fluticasone propionate or equivalent daily dose and high-dose ICS is defined as greater than 400 mcg of fluticasone propionate or equivalent daily dose.

2.) For benralizumab, mepolizumab, or dupilumab only:

Blood eosinophil count: _____ Date (within the past 12 months): _____

3.) Number of clinically significant asthma exacerbations in the past 12 months: _____

Please note: A clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized.

4.) Patients ≥ 12 years of age: Did the patient receive maintenance treatment with oral corticosteroids (OCS) prior to initiation of the requested agent?:

☐ **Yes** OCS: _____ Current Daily Dose: _____ ☐ **No**

5.) Baseline ACQ Score: _____ Date: _____

RENEWAL REQUEST

1.) Current ACQ Score: _____ Date: _____

2.) Patients ≥ 12 years of age: Current daily maintenance OCS dose: _____ ☐ No daily maintenance OCS

3.) Number of clinically significant asthma exacerbations within the previous 12 months: _____ ☐ No exacerbations

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