NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
Dabigatran, Rivaroxaban, Apixaban or Edoxaban

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

DOSE REQUESTED

☐ Dabigatran 110mg BID	☐ Rivaroxaban 15mg OD	☐ Apixaban 2.5mg BID	☐ Edoxaban 30mg OD
☐ Dabigatran 150mg BID	☐ Rivaroxaban 20mg OD	☐ Apixaban 5mg BID	☐ Edoxaban 60mg OD

DIAGNOSTIC INFORMATION

DIAGNOSIS:

1. ☐ Treatment of deep vein thrombosis (DVT) or pulmonary embolus (PE) (Rivaroxaban, Apixaban, and Edoxaban only).

Date of DVT/PE: _____

Coverage duration: 6 months. Patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Creatinine clearance [CrCl]: _____ mL/min Date: _____

2. ☐ Non-valvular atrial fibrillation (AF) $CHADS_2$ score: _____

► Creatinine clearance [CrCl]: _____ mL/min Date: _____

Agents Tried:	**Dose, length of therapy, & outcome (i.e., inadequate anticoagulation*, etc.):**
☐ Warfarin	
►Percentage out of range on warfarin:	
☐ Other: _____	

* Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period. A reasonable trial on warfarin is defined as at least two months of therapy.

If warfarin has not been tried, please indicate the reason why:

_____

_____

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

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NOVA SCOTIA