# NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
## Request for Coverage of Entresto (sacubitril/valsartan)

### PATIENT INFORMATION

| PATIENT SURNAME | PATIENT GIVEN NAME | HEALTH CARD NUMBER | DATE OF BIRTH |
|---|---|---|---|
| | | | |

**PATIENT ADDRESS**

### DIAGNOSTIC INFORMATION

**For the treatment of heart failure (HF) with reduced ejection fraction in patients with New York Heart Association (NYHA) class II or III HF to reduce the incidence of cardiovascular (CV) death and HF hospitalization, if ALL of the following clinical criteria are met:**

☐ Reduced left ventricular ejection fraction (LVEF) (< 40%)

☐ NYHA class II to III symptoms despite at least four weeks of optimal treatment of the following:

- ☐ a stable dose of an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor blocker (ARB); AND
- ☐ a stable dose of a beta blocker; AND
- ☐ other therapies, including an aldosterone antagonist (if tolerated)

☐ Plasma B-type natriuretic peptide (BNP) ≥ 150 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) ≥ 600 pg/mL **OR**

☐ Plasma B-type natriuretic peptide (BNP) ≥ 100 pg/mL or N-terminal prohormone B-type natriuretic peptide (NT-proBNP) ≥ 400 pg/mL if the patient has been hospitalized for heart failure within the past 12 months

If BNP testing is not accessible, the reasons must be clearly outlined:

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Initiation and up-titration should be conducted by a prescriber experienced with the treatment of heart failure.

### MEDICATIONS (DRUG, DOSE AND DURATION)*

*** If the patient is presently on therapy with Entresto (sacubitril/valsartan), please provide details of therapy prior to Entresto, as well as the start date of therapy with Entresto (sacubitril/valsartan).**

**ACEI or ARB** _____

**Beta-blocker** _____

**Aldosterone antagonist** _____

**Other therapies** _____

**Start date of Entresto, if applicable:** _____

**For patients who have not received four weeks of therapy with an agent above, details must be provided:**

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_____

| 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

**09/2019**