

# NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

## Request for Insured Coverage of Cannabidiol (Epidiolex)

PATIENT INFORMATION			
PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
PATIENT ADDRESS			
INITIAL REQUEST			
For the adjunctive treatment of patients aged 2 years or older with confirmed diagnosis of seizures associated with the following:			
<input type="checkbox"/> <b>Lennox-Gastaut Syndrome:</b>	<input type="checkbox"/> <b>Dravet Syndrome:</b>	<input type="checkbox"/> <b>Tuberous Sclerosis Complex:</b>	
<input type="checkbox"/> Experienced treatment failure on at least 2 antiepileptic drugs <input type="checkbox"/> Currently taking 1 or more antiepileptic drugs at stable doses for at least 4 weeks before initiation <input type="checkbox"/> At least 2 drop seizures per week over a 28-day period before initiation of cannabidiol <input type="checkbox"/> Not concurrently using cannabis or other cannabinoid-based medications	<input type="checkbox"/> Not adequately controlled with 2 or more antiepileptic drugs at the time of initiation <input type="checkbox"/> At least 4 convulsive seizures per month <input type="checkbox"/> Not concurrently using cannabis or other cannabinoid-based medications	<input type="checkbox"/> Currently taking 1 or more antiepileptic drugs at stable doses for at least 4 weeks before initiation <input type="checkbox"/> Experienced treatment failure despite previously or currently receiving treatment with at least 2 antiepileptic drugs <input type="checkbox"/> At least 8 seizures per 28 days before initiation of cannabidiol <input type="checkbox"/> Not concurrently using mTOR inhibitors, cannabis or other cannabinoid-based medications	
MEDICATION TRIALS			
<b>Details of antiepileptic drug trials:</b>			
Drug	Duration	Ongoing?	Outcome
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
RENEWAL REQUEST			
Renewal requests for the treatment of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex diagnosis must provide proof of beneficial clinical effect, without severe toxicity or treatment intolerance. Please advise:			
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

12/2025

