

# NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

## Request for Coverage of Insured Agents for HeFH

| PATIENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                    |               |
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| SURNAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | GIVEN NAME                    | HEALTH CARD NUMBER | DATE OF BIRTH |
| PATIENT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |                    |               |
| DIAGNOSTIC INFORMATION - INITIAL REQUEST FOR COVERAGE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                    |               |
| <b>Requested drug and dosage:</b><br><div style="display: flex; justify-content: space-between;"> <div> <b>Alirocumab (Praluent)</b><br/> <input type="checkbox"/> 75mg/mL   <input type="checkbox"/> 150mg/mL   <input type="checkbox"/> 300mg/2mL </div> <div> <b>Evolocumab (Repatha)</b><br/> <input type="checkbox"/> 140mg/mL </div> <div> <b>Inclisiran (Leqvio)</b><br/> <input type="checkbox"/> 284mg/1.5mL </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                    |               |
| <p>▶ Definite HeFH or Probable HeFH using   <input type="checkbox"/> Simon Broome   <input type="checkbox"/> Dutch Lipid Network   <input type="checkbox"/> Genetic testing</p> <p><input type="checkbox"/> Patient is unable to reach LDL-C target (less than 2.0mmol/L or at least 50% reduction in LDL-C from untreated baseline) despite at least 3 months of continuous treatment with: High-dose statin (e.g., atorvastatin 80 mg, rosuvastatin 40mg) in combination with ezetimibe OR ezetimibe alone if high dose statin not possible due to rhabdomyolysis, contraindication or intolerance</p> <p>▶ Details of statin therapy (drug, dose, duration): _____</p> <p>▶ Details of ezetimibe therapy (duration): _____</p> <p>▶ LDL-C level prior to Praluent, Repatha, or Leqvio including date: _____</p> <p>▶ Start date of Praluent, Repatha, or Leqvio, if applicable: _____</p>                                                                                                                                                                                                                                                                                    |                               |                    |               |
| <p><b>1) For patients currently on a statin but intolerant to high doses, the following details are required:</b></p> <p><input type="checkbox"/> Documented myopathy or abnormal biomarkers (i.e. creatinine kinase greater than 5 times the upper limit of normal) with a trial of at least two statins</p> <p><input type="checkbox"/> For each statin tried dose reduction was attempted, and the intolerance was reversible upon statin discontinuation, but reoccurred with statin re-challenge where clinically appropriate and at least one statin initiated at the lowest daily starting dose</p> <p><input type="checkbox"/> Other known causes of intolerance or abnormal biomarkers have been ruled out</p> <p><b>2) For patients who cannot take a statin due to an intolerance or contraindication (i.e., confirmed rhabdomyolysis, active liver disease, unexplained persistent elevations of serum transaminases exceeding three times the upper limit of normal), please provide details below:</b></p><br><br><br><p><b>3) For patients who cannot take ezetimibe due to an intolerance or contraindication, please provide details below</b></p><br><br><br> |                               |                    |               |
| REQUESTS FOR RENEWAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               |                    |               |
| ▶ LDL-C level: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | Date: _____        |               |
| PRESCRIBER NAME & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               |                    |               |
| _____<br>LICENCE #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | _____<br>PRESCRIBER SIGNATURE | _____<br>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