

NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Coverage of Jardiance (empagliflozin) and Synjardy (empagliflozin/metformin) Diabetes Mellitus Type 2 High Cardiovascular Risk

PATIENT INFORMATION

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

REQUESTED DRUG NAME AND DIAGNOSTIC INFORMATION

Jardiance (empagliflozin): DM Type 2 High Cardiovascular Risk

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular death in patients with type 2 diabetes mellitus and established cardiovascular disease who have inadequate glycemic control despite an adequate trial of metformin.

Inadequate control on metformin: Dose/Duration _____

Must provide details of cardiac risk below:

- History of myocardial infarction (MI)
- Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
- Single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within 12 months prior to selection
- Last episode of unstable angina >2 months prior with confirmed evidence of coronary multi/single vessel disease
- History of ischemic or hemorrhagic stroke
- Occlusive peripheral artery disease

Synjardy (empagliflozin/metformin)

For the treatment of type 2 diabetes mellitus in patients who are already stabilized on therapy with empagliflozin and metformin.

Empagliflozin dose: _____ Metformin dose: _____

Patients must meet coverage criteria for empagliflozin. Please complete relevant form if patient does not already have Pharmacare coverage for empagliflozin.

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

