NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
Request for Coverage of Injectable Vitamin B_{12}

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

DIAGNOSTIC INFORMATION

Please provide the following information if you wish to request insured coverage of the injectable Vitamin B_{12}. Requests will be considered only if oral products are not an option for the above patient.

1. Initiation of Vitamin B_{12} therapy for this patient was based on:

☐ Subnormal Vitamin B_{12} levels, confirmed by laboratory report. Please provide level: _____

☐ Clinical symptoms of deficiency

☐ Other – Please explain: _____

_____

Please note: Vitamin B_{12} levels are required for all patients starting new therapy.

2. Please indicate reason why IM route is necessary:

☐ Severe neurological symptoms

☐ Unable to swallow tablets

☐ Poorly functioning or resected ileum

☐ Other – Please explain: _____

_____

Additional Comments:

_____

_____

_____

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

05/2015

NOVA SCOTIA