NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Coverage of Insured Agents for NMOSD

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

REQUESTED AGENT

☐ **Satralizumab (Enspryng)**	☐ **Inebilizumab (Uplizna)**	☐ **Ravulizumab (Ultomiris)**
Initial Requests: Please complete **Section 1** and **Section 2** below.	**Initial Requests:** Please complete **Section 1** and **Section 3** below.	**Initial Requests:** Please complete **Section 1** and **Section 4** below.

INITIAL REQUEST

SECTION 1: ALL REQUESTS

For the treatment of patients 12 years of age and older (Satralizumab) or adult patients (Inebilizumab, Ravulizumab) with neuromyelitis optica spectrum disorder (NMOSD) who meet all of the following criteria:

☐ Diagnosis of NMOSD

☐ Anti–aquaporin 4 (AQP4) seropositive

☐ **EDSS Score: _____ Date: _____**

Patients must have an EDSS score of 6.5 points or less (Satralizumab requests) or 8 points or less (Inebilizumab requests) or 7 points or less (Ravulizumab requests)

☐ Not initiated during a NMOSD relapse episode

☐ Prescribed by a neurologist with expertise in treating NMOSD

SECTION 2: SATRALIZUMAB REQUESTS

☐ Had at least one relapse of NMOSD in the previous 12 months:

☐ Despite an adequate trial of other accessible preventive treatments[1] for NMOSD, **OR**

☐ Because the patient cannot tolerate other preventive treatments[1] for NMOSD

Preventive Treatment	Dose/Duration	Outcome (Describe effect, contraindication, intolerance, etc.)

[1]Other accessible preventative treatments include, but are not limited to, monoclonal antibodies including rituximab and other immunosuppressants.

SECTION 3: INEBILIZUMAB REQUESTS

☐ Had ≥ 1 attack in the prior 12 months **OR**

☐ Had ≥ 2 attacks in the prior 2 years

SECTION 4: RAVULIZUMAB REQUESTS

☐ Had at least 1 attack or relapse of NMOSD in the previous 12 months

RENEWAL REQUEST

Requests for renewal will be considered for patients who maintain an EDSS score of < 8 points (Satralizumab) or ≤ 8 points (Inebilizumab, Ravulizumab)

EDSS Score: _____ Date: _____

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

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NOVA SCOTIA