NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Non-Insulin Antidiabetic Agents

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

DIAGNOSTIC / DRUG INFORMATION

DIAGNOSIS / INDICATION:

Type II diabetes with inadequate glycemic control on current therapy.

☐ **Insulin is not an option for this patient. Reason:** _____

REQUESTED DRUG NAME / DOSAGE:

DPP-4 inhibitors

- ☐ sitagliptin (Januvia)
- ☐ saxagliptin (Onglyza)
- ☐ linagliptin (Trajenta)

GLP-1 receptor agonist

- ☐ lixisenatide (Adlyxine)*
- ☐ semaglutide (Ozempic)*

* Insulin requirement not applicable

DPP-4 inhibitor combinations

- ☐ sitagliptin/metformin (Janumet)
- ☐ saxagliptin /metformin (Komboglyze)
- ☐ linagliptin/metformin (Jentadueto)

SGLT-2 inhibitors and combinations

- ☐ canagliflozin (Invokana)
- ☐ empagliflozin (Jardiance) †
- ☐ dapagliflozin (Forxiga)‡
- ☐ empagliflozin/metformin (Synjardy) †
- ☐ dapagliflozin/metformin (Xigduo)

† For consideration of coverage for cardiovascular risk, please refer to the section below.

‡ Please refer to published criteria for dapagliflozin (Forxiga) as this agent is not insured in combination with metformin AND a sulfonylurea.

CURRENT MEDICATION/DOSE:

Metformin: _____ Dosage and Duration: _____

Sulfonylurea: _____ Dosage and Duration: _____

Insulin: _____ Dosage and Duration: _____

Other: _____ Dosage and Duration: _____

_____ Dosage and Duration: _____

JARDIANCE (EMPAGLIFLOZIN) AND SYNJARDY (EMPAGLIFLOZIN/METFORMIN) FOR DIABETES MELLITUS AND TYPE 2 HIGH CARDIOVASCULAR RISK:

Please indicate the specific risk factor(s) 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

Please note: For coverage of Synjardy (empagliflozin/metformin), patients must meet coverage criteria 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

NOVA SCOTIA