NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Edaravone (Radicava)

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

INITIAL REQUEST

For the treatment of amyotrophic lateral sclerosis (ALS), if the following criteria are met:

1.) ☐ Patient with a diagnosis of probable ALS or definite ALS; **AND**

Patient who meets all of the following:

2.) ☐ Has scores of at least two points on each item of the ALS Functional Rating Scale – Revised (ALSFRS-R)

3.) ☐ Has a forced vital capacity greater than or equal to 80% of predicted. **FVC:** _____ **Date:** _____

4.) ☐ Has had ALS symptoms for two years or less. **Symptom onset date:** _____

5.) ☐ Patient is not currently requiring permanent non-invasive or invasive ventilation.

RENEWAL REQUEST

Reimbursement of treatment should be discontinued in patients who a) require permanent non-invasive or invasive ventilation OR b) become non-ambulatory (ALSFRS-R score ≤ 1 for item 8) and are unable to cut food and feed themselves without assistance, irrespective of whether a gastrostomy is in place (ALSFRS-R score < 1 for item 5a or 5b).

1.) Has the patient become non-ambulatory (ALSFRS-R score ≤ 1 for item 8)? ☐ YES ☐ NO

ALSFRS-R score for item 8: _____

2.) Is the patient unable to cut food and feed themselves without assistance, irrespective of whether a gastrostomy is in place (ALSFRS-R score < 1 for item 5a or 5b)? ☐ YES ☐ NO

ALSFRS-R score for item 5a: _____ **ALSFRS-R score for item 5b:** _____

3.) Does the patient require permanent non-invasive or invasive ventilation? ☐ YES ☐ NO

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