

NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Coverage of Restricted Rheumatoid Arthritis Drugs

PATIENT INFORMATION			
PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
PATIENT ADDRESS		PATIENT WEIGHT (KG)	
DRUG REQUESTED			
<input type="checkbox"/> Tofacitinib Tab <input type="checkbox"/> Infliximab <input type="checkbox"/> Etanercept <input type="checkbox"/> Adalimumab <input type="checkbox"/> Abatacept SC, IV <input type="checkbox"/> Certolizumab pegol <input type="checkbox"/> Golimumab <input type="checkbox"/> Tocilizumab SC, IV			
NOTE: Please refer to Nova Scotia Formulary for criteria and notes for coverage of Rheumatoid Arthritis drugs. For coverage for Rituximab, please refer to the Rituximab request form.			
DIAGNOSTIC INFORMATION			
DIAGNOSIS: <input type="checkbox"/> Severely active Rheumatoid Arthritis (RA)			
MEDICATION HISTORY: (if completed on a previous request, provide updated information only)			
Therapies tried	Dose/Route	Duration of therapy	Outcome (describe intolerance, effect, etc.)
<input type="checkbox"/> Methotrexate	_____	_____	_____
<input type="checkbox"/> Sulfasalazine	_____	_____	_____
<input type="checkbox"/> Hydroxychloroquine	_____	_____	_____
<input type="checkbox"/> Leflunomide	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____
List which combinations of therapies have been tried:			
Drug combinations	Dose/Route	Duration of therapy	Outcome (describe intolerance, effect, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
▶ If triple DMARD therapy was not tried describe why: _____			

If requesting continuation of coverage, please describe level of improvement of symptoms: _____ _____			
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