NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Coverage of Insured Agents for Ulcerative Colitis

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS	PATIENT WEIGHT (KG)

DRUG REQUESTED

- ☐ Adalimumab
- ☐ Golimumab
- ☐ Infliximab
- ☐ Ozanimod (adult patients)
- ☐ Tofacitinib Tab (adult patients)
- ☐ Ustekinumab
- ☐ Vedolizumab (adult patients)

NOTE: Please refer to the Nova Scotia Formulary for criteria and notes for coverage of Ulcerative Colitis medications.

DIAGNOSTIC INFORMATION

DIAGNOSIS

☐ Moderately to severely active ulcerative colitis (UC) with:

Partial Mayo score: _____ Date: _____ **AND**

Rectal bleeding subscore: _____ Date: _____

MEDICATION HISTORY: (if completed on a previous request, provide updated information only)

☐ Refractory or intolerant to conventional therapy (i.e. 5-ASA for a minimum of 4 weeks, and prednisone ≥ 40mg daily for two weeks or IV equivalent for one week); **OR**

☐ Corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.)

Please provide details below:

Therapies tried	Dose/Route	Duration of therapy	Outcome (describe intolerance, effect, etc.)
☐ 5-ASA			
☐ Prednisone			
☐ Other:			

RENEWAL REQUEST

Partial Mayo score: _____ Date: _____ **AND**

Rectal bleeding subscore: _____ Date: _____

Comments (if applicable):

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

07/2024

NOVA SCOTIA