Nova Scotia Provincial Pharmacare Programs

Request for Coverage of Chronic Obstructive Pulmonary Disease (COPD) Therapy

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

DIAGNOSTIC INFORMATION

Post bronchodilator-FEV_1 (% predicted): _____ | **Post bronchodilator-FEV_1/FVC ratio: _____** | **MRC Dyspnea Scale Grade: _____**

☐ **Asthma/COPD (ACO) overlap** – Please provide supporting details (patient symptoms, risk factors, spirometry, etc.):

_____

_____

COPD Assessment Test (CAT) Score _____

☐ Hospitalized for acute severe COPD exacerbation in last 12 months

☐ Two or more moderate COPD exacerbations in the last 12 months requiring antibiotics/systemic corticosteroids

►If spirometry can not be obtained, please provide the details why **AND** provide the MRC Dyspnea Scale grade to indicate COPD severity:

Explanation:_____

_____

REQUESTED THERAPY

► **Section 1: Request for Long Acting $Beta_2$-Agonist (LABA) Monotherapy:**
☐ Serevent Diskus

► **Section 2: Request for Long Acting Muscarinic Antagonist (LAMA) Monotherapy:**
☐ Spiriva Respimat ☐ Spiriva Handihaler ☐ Incruse Ellipta ☐ Seebri Breezhaler ☐ Tudorza Genuair

► **Section 3: Request for Long Acting $Beta_2$-Agonist (LABA)/Inhaled Steroid (ICS) Monotherapy for Asthma/COPD Overlap:**
☐ Advair ☐ Symbicort ☐ Breo Ellipta

► **Section 4: Request for LAMA/LABA Dual Therapy: (combination of single agent LABA and LAMA will not be considered)**
☐ Anoro Ellipta ☐ Duaklir Genuair ☐ Inspiolto Respimat ☐ Ultibro Breezhaler
☐ Has been on a LABA or LAMA for at least 1 month. Inhaler: Start date:

► **Section 5: Request for LABA/ICS + LAMA or ICS/LAMA/LABA (combined in one inhaler)**
☐ Advair ☐ Symbicort ☐ Breo Ellipta

LAMA (please specify) _____

☐ Trelegy Ellipta (Start Date if applicable): _____ ☐ Breztri Aerosphere (Start Date if applicable): _____

For Triple Therapy:

☐ Symptomatic despite at least two months of treatment with LABA/ICS or LAMA/LABA.

Details of prior inhaler therapy:

Inhaler: _____ Start Date: _____

Inhaler: _____ Start 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

NOVA SCOTIA

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