Nova Scotia Provincial Pharmacare Programs

Request for Coverage of Restricted Psoriatic Arthritis Drugs

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

DRUG REQUESTED

- ☐ Adalimumab
- ☐ Certolizumab pegol
- ☐ Etanercept
- ☐ Golimumab
- ☐ Guselkumab
- ☐ Infliximab
- ☐ Ixekizumab
- ☐ Secukinumab
- ☐ Upadacitinib

NOTE: Please refer to Nova Scotia Formulary for criteria and notes for coverage of Psoriatic Arthritis drugs

DIAGNOSTIC INFORMATION

DIAGNOSIS:

☐ predominantly axial psoriatic arthritis ☐ predominantly peripheral psoriatic arthritis

MEDICATION HISTORY

DMARDs tried	Dose/Route	Duration of therapy	Outcome (describe intolerance, effect, etc.)
☐ Methotrexate			
☐ Leflunomide			
☐ Sulfasalazine			

NSAIDs tried

Drug	Dose/Route	Duration of therapy	Outcome (describe intolerance, effect, etc.)

REQUEST FOR CONTINUED COVERAGE

☐ **Patient continues to respond to therapy**

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