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

- ☐ Abatacept SC, IV
- ☐ Adalimumab
- ☐ Certolizumab pegol
- ☐ Etanercept
- ☐ Golimumab
- ☐ Infliximab
- ☐ Sarilumab
- ☐ Tocilizumab SC, IV
- ☐ Tofacitinib Tab
- ☐ Upadacitinib

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.

INITIAL REQUEST

DIAGNOSIS

☐ Severely active Rheumatoid Arthritis (RA)

MEDICATION HISTORY:

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

RENEWAL REQUEST

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

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