NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

REQUEST FOR COVERAGE FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) THERAPY

PATIENT INFORMATION

PATIENT'S SURNAME	PATIENT'S GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT'S ADDRESS

DRUG REQUESTED

☐ Formoterol (Foradil®, Oxeze®) ☐ Formoterol/Budesonide (Symbicort®) ☐ Tiotropium Bromide (Spiriva®)

☐ Salmeterol (Serevent®) ☐ Salmeterol/Fluticasone (Advair®)

A combination of tiotropium and a long-acting beta$_2$ agonist (LABA) without an inhaled corticosteroid will not be approved.

DIAGNOSTIC INFORMATION

Current / Past Therapies for COPD: *(indicate drug, dosage, duration)*

_____

_____

_____

Maximum doses of short-acting bronchodilators (8 puffs/day of salbutamol, or 12 puffs/day of ipratropium) must be tried first for 2-3 months, unless the patient has moderate to severe COPD. Information to be provided below.

Severity of Condition

Information only required if maximum doses of short-acting agents have not already been tried or if requesting coverage of tiotropium plus LABA/steroid combination.

Postbronchodilator values: FEV_1 % Predicted _____ FEV_1/FVC ratio _____

Number of acute exacerbations in last 2 years requiring treatment with antibiotics/steroids: _____
(Only required if requesting coverage of tiotropium plus LABA/steroid combination)

Under the unusual circumstance that spirometry cannot be obtained, please explain why and indicate the severity of the condition below:

Explanation: _____

☐ *MODERATE** - shortness of breath from COPD causing the patient to stop after walking about 100 meters (or after a few minutes) on the level. (MRC* 3-4)

☐ *SEVERE** - shortness of breath from COPD resulting in the patient being too breathless to leave the house or breathless after undressing (MRC* 5), or the presence of chronic respiratory failure or clinical signs of right heart failure.

*Canadian Thoracic Society COPD Classification By Symptom/Disability. *MRC= Medical Research Council Dyspnea Scale

COMMENTS:

PHYSICIAN'S NAME & ADDRESS:

CPSNS #: _____

_____ _____
PHYSICIAN'S SIGNATURE **DATE**

Please Return Form To: Nova Scotia Pharmacare Department, P.O. Box 500, Halifax, NS B3J 2S1 FAX: (902) 468-9402