NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
REQUEST FOR COVERAGE OF RESTRICTED RHEUMATOID ARTHRITIS DRUGS

PATIENT INFORMATION

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

DIAGNOSIS:

☐ Rheumatoid Arthritis (RA) ☐ Other: ______________________________

Approximate year patient was diagnosed, if known: ____________

REQUESTED DRUG NAME:

☐ Leflunomide ☐ Infliximab ☐ Etanercept ☐ Adalimumab (maximum dose 40mg q 2 weeks)

☐ Abatacept ☐ Golimumab (maximum dose 50mg per month) ☐ Tocilizumab (maximum dose 800mg q 4 weeks)

MEDICATION HISTORY: (If completed on a previous request, provide update information only.)

Check agents tried as monotherapy:	LENGTH OF THERAPY & OUTCOME (i.e. intolerant, not effective, etc.)
☐ Methotrexate	____________
☐ IM Gold (sodium aurothiomalate)	____________
☐ Sulfasalazine	____________
☐ Hydroxychloroquine	____________
☐ Azathioprine	____________
☐ Chloroquine	____________
☐ Penicillamine	____________
☐ Cyclosporine	____________
☐ Leflunomide	____________
☐ Other	____________
	____________

List which combinations of therapies have been tried:

DRUG COMBINATIONS	LENGTH OF THERAPY & OUTCOME

If requesting continuation of coverage, please indicate level of improvement of symptoms:

☐ <20% ☐ 20% ☐ 50% ☐ 70%

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

APPENDIX III