NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

REQUEST FOR INSURED COVERAGE OF EXCEPTION STATUS DRUG

P A T I E N T   I N F O R M A T I O N

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

PATIENT'S ADDRESS

D I A G N O S T I C / D R U G   I N F O R M A T I O N

DIAGNOSIS / INDICATION:

REQUESTED DRUG NAME/DOSAGE:

REASON FOR REQUEST:

EXPLAIN:

- CONTRAINDICATION ☐
- ADVERSE EVENT ☐
- THERAPEUTIC FAILURE ☐
- OTHER ☐

OTHER COMMENTS (if applicable):

PHYSICIAN'S NAME & ADDRESS

CPSNS #:__________

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PHYSICIAN'S SIGNATURE

____
DATE

07/2008

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