NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

REQUEST FOR INSURED COVERAGE OF INJECTABLE VITAMIN B_{12}

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

Please provide the following information if you wish to request insured coverage of the <u>injectable</u> Vitamin B_{12}. Requests will be considered only if oral products are not an option for the above patient.

1. Initiation of Vitamin B_{12} therapy for this patient was based on:

☐ Subnormal Vitamin B_{12} levels, confirmed by laboratory report. Please provide level: _____

☐ Clinical symptoms of deficiency

☐ Other, please explain: _____

_____

Please note: Vitamin B_{12} levels are required for all patients starting new therapy.

2. Please indicate reason why IM route is necessary:

☐ Severe neurological symptoms

☐ Unable to swallow tablets

☐ Poorly functioning or resected ileum

☐ Other, please explain: _____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

_____

PHYSICIAN'S NAME & ADDRESS:

CPSNS #: _____

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

11/2002

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