

NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

REQUEST FOR COVERAGE OF CLOPIDOGREL (PLAVIX® 75mg Daily)

PATIENT INFORMATION			
PATIENT'S SURNAME	PATIENT'S GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
PATIENT'S ADDRESS			
<p>Intravascular Stent Implantation:</p> <p>Please check the type of stent inserted:</p> <p><input type="checkbox"/> Bare Metal Stent(s) (BMS) – 30 days</p> <p><input type="checkbox"/> Drug Eluting Stent(s) (DES) – 12 months</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px; width: fit-content;"> <p><i>Indicating Criteria Code "30" on the prescription will allow the pharmacist to bill the first month of therapy. For longer term coverage (i.e., DES) please also forward completed form to the Pharmacare office.</i></p> </div>			
<p>Non-ST-Elevation Acute Coronary Syndrome</p> <p><input type="checkbox"/> Non-ST-segment elevation acute coronary syndrome in combination with ASA (unstable angina or non-ST-segment elevation myocardial infarction) – 90 days</p> <p style="margin-left: 20px;"><input type="checkbox"/> High Risk Patient (must indicate risks below) – 12 months</p> <p style="margin-left: 40px;"><input type="checkbox"/> Second ACS within 12 months</p> <p style="margin-left: 40px;"><input type="checkbox"/> Complex or extensive CAD (e.g., diffuse 3 vessel CAD not amenable to revascularization)</p> <p style="margin-left: 40px;"><input type="checkbox"/> Previous stroke, TIA or symptomatic PAD</p>			
<p>Long-term monotherapy (alternative to ASA) for secondary prevention in a patient who has had one of the following vascular ischemic events:</p> <p>Ischemic Stroke/Transient Ischemic Attack (TIA)</p> <p><input type="checkbox"/> Experienced a recurrent thrombotic event (stroke, symptoms of TIA) while taking ASA</p> <p><input type="checkbox"/> Documented severe allergy to ASA</p> <p><input type="checkbox"/> GI hemorrhage while on ASA</p> <p>Unstable Angina or Myocardial Infarction or Peripheral Vascular Disease</p> <p><input type="checkbox"/> Documented severe allergy to ASA</p> <p><input type="checkbox"/> GI hemorrhage while on ASA</p>			
<p>Comments:</p> 			
<p>PHYSICIAN'S NAME & ADDRESS:</p> <p style="text-align: right;">CPSNS #: _____</p>		<p style="text-align: center;">_____ PHYSICIAN'S SIGNATURE</p> <p style="text-align: right;">_____ DATE</p>	