NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
REQUEST FOR COVERAGE OF ANTI-TNF AGENTS FOR PSORIASIS

PATIENT INFORMATION

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

REQUEST FOR INITIAL COVERAGE

DIAGNOSIS:

Patient has severe debilitating chronic plaque psoriasis as defined by:

☐ Body Surface Area (BSA) involvement > 10%

AND/OR ☐ Significant involvement of the face, hands, feet or genital region

REQUESTED DRUG NAME AND DOSE:

☐ Adalimumab (Humira ®) Dose __________
- initial approval for a maximum of 16 weeks
- maximum dosage for ongoing coverage is 40mg q 2 weeks

☐ Etanercept (Enbrel ®) Dose __________
- initial approval for a maximum of 12 weeks
- maximum dosage approved: 50mg biweekly x initial 12 weeks then 50mg weekly thereafter

☐ Infliximab (Remicade®) Dose __________
- initial approval for a maximum of 12 weeks
- dosage restricted to 5mg/kg at 0.2 and 6 weeks - then every 8 weeks thereafter

☐ Ustekinumab (Stelara®) Dose __________
- initial approval for a maxium of 16 weeks
- dosage restricted to 45mg at 0, 4, and 16 weeks – then every 12 weeks thereafter

PATIENT'S PAST MEDICATION HISTORY:

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

AGENTS TRIED:	LENGTH OF THERAPY & OUTCOME: (i.e., intolerant, not effective, etc.)
☐ Methotrexate	______________________________
☐ Cyclosporine	______________________________
☐ Phototherapy	______________________________

PATIENT'S CURRENT THERAPY:

ADDITIONAL 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