

NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

REQUEST FOR COVERAGE FOR SELECTIVE 5HT₁ – RECEPTOR AGONISTS

PATIENT INFORMATION			
PATIENT'S SURNAME	PATIENT'S GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
DRUG REQUESTED			
<input type="checkbox"/> Sumatriptan tablets <i>For all new requests for coverage, oral sumatriptan will be the first triptan insured. Coverage of other triptans may be provided upon failure of oral sumatriptan.</i>			
<input type="checkbox"/> Almotriptan (Axert®) <input type="checkbox"/> Rizatriptan (Maxalt®, Maxalt RPD®) <input type="checkbox"/> Sumatriptan nasal spray (Imitrex®) <input type="checkbox"/> Naratriptan (Amerge®) <input type="checkbox"/> Zolmitriptan (Zomig®)			
Reason why Sumatriptan tablets cannot be used: <input type="checkbox"/> Contraindication <input type="checkbox"/> Adverse event <input type="checkbox"/> Therapeutic failure <input type="checkbox"/> Other, please explain: _____			
<input type="checkbox"/> Sumatriptan 6mg/0.5mg Injection (Imitrex®) Reason why oral and nasal triptans are not appropriate: _____			
NOTE: Coverage is limited to 18 doses every 3 months. Patients with more than 3 migraines a month who are on prophylactic therapy may qualify for additional doses, upon written request.			
DIAGNOSTIC INFORMATION			
Current / Past Therapies for Migraine: <i>(indicate drug, dosage, duration)</i> _____ _____ * Patient must try other therapies (e.g., NSAIDs, acetaminophen, DHE spray) first, unless the patient has severe or ultra severe migraine attacks. Severity of Condition¹ <input type="checkbox"/> <u>MODERATE</u> – pain is distracting causing need to slow down and limit activities. <input type="checkbox"/> <u>SEVERE</u> – pain affects ability to concentrate and very difficult to continue with daily activities. <input type="checkbox"/> <u>ULTRA SEVERE</u> – unable to speak or think clearly; not able to function; likely lying down or sleeping.			OFFICE USE ONLY: STATUS: <input type="checkbox"/> A _____ <input type="checkbox"/> N-I _____ <input type="checkbox"/> M-I _____ DATE: _____ INITIALS: _____ / _____ EFF: _____ EXP: _____ CONTACT: P D C
PHYSICIAN'S NAME & ADDRESS: <div style="text-align: right;">CPSNS #: _____</div>		<div style="text-align: right;"> _____ PHYSICIAN'S SIGNATURE _____ DATE </div>	