


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

PATIENT INFORMATION											
PATIENT'S SURNAME <i>Sample</i>	PATIENT'S GIVEN NAME <i>Patient</i>	HEALTH CARD NUMBER <i>0001 000 009</i>	DATE OF BIRTH <i>1982/03/14</i>								
REQUEST FOR <u>INITIAL</u> COVERAGE											
<u>DIAGNOSIS:</u> Patient has severe debilitating chronic plaque psoriasis as defined by: <input type="checkbox"/> Body Surface Area (BSA) involvement > 10% AND/OR <input checked="" type="checkbox"/> Significant involvement of the face, hands, feet or genital region											
<u>REQUESTED DRUG NAME AND DOSE:</u> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input checked="" type="checkbox"/> Adalimumab (Humira[®]) Dose <u>30 mg</u> - initial approval for a maximum of 16 weeks - maximum dosage for ongoing coverage is 40mg q 2 weeks </div> <div style="width: 45%;"> <input type="checkbox"/> 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 </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Etanercept (Enbrel[®]) Dose _____ - initial approval for a maximum of 12 weeks - maximum dosage approved: 50mg biweekly x initial 12 weeks then 50mg weekly thereafter </div> <div style="width: 45%;"> <input type="checkbox"/> Ustekinumab (Stelara[®]) Dose _____ - initial approval for a maximum of 16 weeks - dosage restricted to 45mg at 0, 4, and 16 weeks – then every 12 weeks thereafter </div> </div>											
<u>PATIENT'S PAST MEDICATION HISTORY:</u> (If completed on a previous request, provide update information only.) <table style="width:100%; border: none;"> <tr> <td style="width: 25%;"><u>AGENTS TRIED:</u></td> <td style="width: 75%;"><u>LENGTH OF THERAPY & OUTCOME:</u> (i.e., intolerant, not effective, etc.)</td> </tr> <tr> <td><input type="checkbox"/> Methotrexate</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Cyclosporine</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Phototherapy</td> <td>_____</td> </tr> </table>				<u>AGENTS TRIED:</u>	<u>LENGTH OF THERAPY & OUTCOME:</u> (i.e., intolerant, not effective, etc.)	<input type="checkbox"/> Methotrexate	_____	<input type="checkbox"/> Cyclosporine	_____	<input type="checkbox"/> Phototherapy	_____
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<input type="checkbox"/> Cyclosporine	_____										
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<u>PATIENT'S CURRENT THERAPY:</u> <i>Aenean non porttitor sem. Duis tempus accumsan massa at imperdiet. Vivamus congue scelerisque risus, fringilla rhoncus dolor adipiscing quis. Sed auctor odio venenatis ligula pellentesque euismod. Duis arcu nulla, varius eget scelerisque sed, venenatis sit amet quam. Proin justo est, volutpat ut lacus ac, congue facilisis mauris. Mauris elementum, dui vitae commodo consequat, lacus augue ultricies quam, ut porttitor est odio sed nulla. Donec fermentum, dolor sit amet dictum fringilla, nulla erat semper lectus, in bibendum magna leo nec dolor.</i>											
<u>ADDITIONAL COMMENTS:</u> <i>Mauris in urna ullamcorper, laoreet dolor vitae, varius nunc. Class aptent taciti sociosqu ad litora torquent per conubia nostra, per inceptos himenaeos. Aenean dapibus ut est lobortis dictum. Sed sagittis sapien in tellus aliquam posuere. Morbi consequat viverra nibh at aliquam. Phasellus lorem dui, tristique eu elementum ac, suscipit at enim. Aenean eu est pharetra, accumsan neque ut, facilisis sem. Vestibulum at dui a ipsum luctus dictum in</i>											
PHYSICIAN'S NAME & ADDRESS: DR. REQUESTING PHYSICIAN IWK DI PHYSICIANS 123 Main St. Halifax, Nova Scotia B2B 2B2 CPSNS #: <u>0369423</u>		<div style="text-align: center;">  _____ PHYSICIAN'S SIGNATURE </div> <div style="text-align: right; margin-top: 10px;"> <u>2014/05/29</u> DATE </div>									