Manitoba

Vascepa / Icosapent ethyl

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

FAX: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	Fax Number: Phone Number:
Prescriber Address:	Prescriber License Number (NOT Billing Number):

Patient's First Name:	PHIN:	MH Registration Number:
Patient's Last Name:	Patient's Date of Birth:	
Requested Medication Name and Strength:	Expected Dosing:	Expected Therapy Duration:

Exception Drug Status (EDS) approval is granted only upon demonstration that the patient meets the specified EDS criteria. Please provide the following details to support the meeting of EDS criteria by the patient.

Diagnosis/Indication:	______________________________

Patient Information	YES	NO
The patient is aged 45 years or older.		
Patient has established cardiovascular disease (CVD) as defined as history of (please check all that applies): • Coronary artery disease (eg. myocardial infarction, angina, coronary procedure, abdominal aortic aneurysm) • Cerebrovascular disease (eg. stroke, transient ischemic attack, carotid obstruction) • Peripheral artery disease		

Baseline Information (Results must be obtained within the preceeding 3 months of starting Vascepa)			
Baseline fasting triglyceride level	______________ mmol/L	Test Date	______________
Baseline low-density lipoprotein cholesterol (LDL-C) level	______________ mmol/L	Test Date	______________

Statin Information		
Patient is currently receiving a maximally tolerated dose of statin for a minimum of 4 weeks.	YES	NO
Name of Statin patient is currently on	______________________	
Current Statin Dose	______________________	
Statin Start Date	______________________	

Prescriber Signature and Date:			
Date:		Prescriber Signature:	