EXTENSION REQUEST FORM for Medical Cannabis

Workers' Compensation Board of Nova Scotia

WCB Claim # **Mandatory**

Please complete **all** sections clearly and with detail to allow your request to be processed without delay.
Use additional pages if necessary. This form must be completed by the authorizer and **submitted to Medavie Blue Cross [Fax 902-496-5819].**

If this is a **FIRST REQUEST** for coverage for this worker, please use the **Initial Request Form for Medical Cannabis**.

ALL requests for coverage will be evaluated against WCB's Medical Cannabis Coverage Criteria.
Please review the criteria to ensure coverage will be considered.

Worker Information

Last Name	First Name	Initial	Date of Birth (DD/MM/YYYY)
Street	City	Postal Code	HCN

Injury Information

Date of injury (DD/MM/YYYY)	Diagnosis	Comorbid conditions

Assessment

1. Date of Patient Assessment: _____
   DD/MM/YYYY

2. Date Medical Cannabis First Approved: _____
   DD/MM/YYYY

3. Has there been a change in the symptoms or conditions treated? Please describe the changes(s) and quantify (narrative or list assessment tools/scores)

4. Please indicate the weekly average numerical level of function/pain since last assessment

Function	Pain
0 = pre-injury functional level 10 = severe impact on function at home and work	0 = no pain at all 10 = persistent severe pain
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. Has there been an overall improvement in function/pain since starting medical cannabis?

Function	Pain
☐ YES – function has improved ☐ NO – function has not improved PROVIDE DETAILS IN Q # 6 BELOW	☐ YES – pain has improved ☐ NO – pain has not improved PROVIDE DETAILS IN Q #7 BELOW

6. How has your patient's **function changed** since starting medicinal cannabis or since the date of the last review?

7. How has your patient's **pain changed** since starting medicinal cannabis or since the date of the last review?

8. Has your patient experienced any side effects and, if so, what mitigation strategies were discussed?

9. Do you have any concerns for your patient regarding side effects and/or adverse events associated with cannabis use? Check one answer for each selection:

Risk	Concern?	IF YES – Please explain:
Physical/psychological side effects	☐ NO ☐ YES	
Cannabis dependence	☐ NO ☐ YES	
Relapse/Previous substance abuse disorder	☐ NO ☐ YES	
Driving impairment	☐ NO ☐ YES	
Ability to perform/function at work	☐ NO ☐ YES	
Ability to meet work site safety standards/tasks	☐ NO ☐ YES	
Ability to actively participate in rehabilitation plan/program	☐ NO ☐ YES	

10. Have there been any new medical conditions or worsening of pre-existing medical conditions since starting medical cannabis?

11. Have there been **any** changes in medications since the last assessment? IF YES: please provide details:

Treatment Plan

12. What are the **revised measurable functional goals** of treatment using cannabis?

13. Please specify the details of the medical cannabis authorization:

Per national guidelines, medical cannabis should ideally be CBD rich and of low potency THC, with total daily consumption of THC generally no more than 30 mg and, under no circumstances, above 75 mg. In addition, the parameters of no more than 3 grams daily and maximum potency of 9% THC must be satisfied. It is the responsibility of the authorizer and supplier to ensure the amount and dosage does not exceed these limits.

WCB supports a "low and slow" approach to dosing, and will not cover smoking as a mode for medical cannabis administration.

This patient has medical authorization for _____ grams of cannabis per day for _____ duration.

Mode(s) of administration: ☐ Vaporized ☐ Oil

For Dried Cannabis:

	Strain/Product Name	% THC	% CBD
1.			
2.			
3.			

THC Dosage: _____mg of THC/day

- Q x P = mg of THC per day, where **Q** is the **daily quantity of dried medical cannabis** expressed in milligrams (e.g., one gram per day equals 1000 mg per day) and **P** is the **THC percentage** of the dried cannabis expressed as a decimal (e.g., 0.02 for two per cent THC)

For Oil Formulations:

	Product Name	% THC	% CBD	Concentration of THC (mg/mL)	Concentration of CBD (mg/mL)	Daily dose (mL)
1.						
2.						
3.						

THC Dosage: _____mg of THC/day ***[Note: Authorizer may need to refer to conversion information from Licensed Producer.]***

Cannabis brand or identifier: _____

Licensed producer name: _____

Prescriber name: _____ Date: _____
DD/MM/YYYY

Prescriber signature: _____

License #: _____

Fax # (mandatory): _____ Phone #: _____

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Physicians: use MSI fee code **WCB30**. Other prescribers: invoice WCB directly.

Please return completed form to Medavie Blue Cross by fax to (902) 496-5819 or by mail to PO Box 2200 Halifax, NS B3J 3C6