MEDAVIE BLUE CROSS™

INITIAL 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 prescriber and **submitted to Medavie Blue Cross [Fax 902-496-5819].**

If you are requesting an **EXTENSION** of coverage or adjustment to approved dosage, please complete and submit the **Extension 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.

Date of request: _____
DD/MM/YYYY

Date of your last physical exam of this worker: _____ (In-person physical exam is required)
DD/MM/YYYY

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

1. Are you the primary treating health professional responsible for managing the on-going care of this worker? ☐ NO ☐ YES

2. IF **NO**: Is the primary treating health professional both aware and supportive of medical cannabis treatment? ☐ NO ☐ YES
   Name of primary treating health professional: _____

3. Do you agree to be responsible for on-going management and monitoring of the injury and condition being treated with medical cannabis? ☐ NO ☐ YES
   IF NO: Requests for medical cannabis coverage will not be evaluated unless the authorizer agrees to monitor the condition being treated.

Diagnosis/Condition

4. What is the diagnosis responsible for your patient's symptoms?

5. Please describe the signs, symptoms and objective medical findings supporting the diagnosis

Pharmaceutical Therapies Trialed

6. If the working diagnosis is **refractory neuropathic pain** please complete the following table (attach another page if necessary):

Name of medication	Date initiated (DD/MM/YYYY)	Maximum dosage achieved	Beneficial effects	Adverse effects	Reason for discontinuation (if applicable)	Date discontinued (DD/MM/YYYY)
FIRST LINE AGENTS:						
TCAs:						
SNRIs:						
GABAPENTINOIDS (gabapentin/pregabalin):						
SECOND LINE AGENTS:						
TRAMADOL/OPIOIDS:						

Name of medication	Date initiated (DD/MM/YYYY)	Maximum dosage achieved	Beneficial effects	Adverse effects	Reason for discontinuation (if applicable)	Date discontinued (DD/MM/YYYY)
THIRD LINE AGENTS:						
SYNTHETIC CANNABINOIDS: (NOTE: REQUESTS WILL **NOT** BE CONSIDERED UNLESS WORKER HAS FAILED ADEQUATE TRIAL OF A SYNTHETIC CANNABINOID)						
OTHERS (including medical cannabis):						

If **fewer than three** categories above were trialed, please provide reason(s):

7. Please list all current medications prescribed or medically authorized for your patient which are **NOT** for the condition listed above (attach another page if necessary).

Name of Medication	Dosage & Frequency	Indicated condition

Risk Assessment

8. To the best of your knowledge, indicate if each of the following applies to your patient:

Under age 25	☐ NO ☐ YES ☐ UNSURE
Has a personal or strong family history of psychosis	☐ NO ☐ YES ☐ UNSURE
Has a current or past cannabis use disorder	☐ NO ☐ YES ☐ UNSURE
Has an active substance use disorder	☐ NO ☐ YES ☐ UNSURE
Is pregnant, planning to become pregnant, or breast-feeding	☐ NO ☐ YES ☐ UNSURE
Has cardiovascular disease	☐ NO ☐ YES ☐ UNSURE
Has respiratory disease	☐ NO ☐ YES ☐ UNSURE
Has an uncontrolled or recurrent anxiety/mood disorder (if yes/unsure, provide details in Q # 9 below)	☐ NO ☐ YES ☐ UNSURE

9. Please list all current and past psychological/psychiatric conditions.
   For each condition, indicate if treatment is on-going or concluded and describe treatment details including:
   – Under care of a psychiatrist/psychologist
   – How often followed
   – Medications
   – Current status (stability, responding to treatment)

10. If your patient is taking opioids, benzodiazepines or other sedating medications, prescribed or OTC, and medical cannabis is added please describe your plan for the other medications.

11. Does your patient:

Consume alcohol?	☐ NO ☐ YES	**IF YES:** _____ drinks per week _____ years of regular drinking
Smoke tobacco?	☐ NO ☐ YES	**IF YES:** _____ cigarettes per day _____ years of regular tobacco use
Have any risk factors for cardiovascular disease?	☐ NO ☐ YES	**IF YES – list risk factors:**
Use cannabis recreationally?	☐ NO ☐ YES	**IF YES:** _____ grams per day _____ years of recreational cannabis use

12. 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:
Medical/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	

13. Have you completed a cannabis treatment agreement with your patient, which includes instruction regarding concurrent recreational usage? ☐ YES

NOTE: A treatment agreement must be completed and acknowledged here before this request will be processed.
A sample treatment agreement is available on the WCB website.

Treatment Goals

14. What are the objectives for medical cannabis treatment?

15. Please indicate the weekly average numerical level of function/pain (baseline)

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

16. What are the measurable functional goals for medical cannabis treatment (e.g., improvements or achievement of specific functions and/or activities)?

17. How do you intend to measure and track progress toward the treatment objectives and functional goals (e.g., formalized tool such as SF-36 or others)?

Treatment Plan

18. 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 **WCB29**. 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