Ofev / Nintedanib

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:	☐ **Idiopathic pulmonary fibrosis (IPF)** ☐ **Chronic fibrosing interstitial lung disease with a progressive phenotype (progressive fibrosing ILD)** ☐ **Other – Please specify: _____**

Treatment Initiation

For All Patients - Baseline Information (Prior to OFEV Initiation)

Patient's baseline % predicted Forced Vital Capacity (FVC): _____

Date on which baseline FVC was obtained: _____

For Patients with Idiopathic Pulmonary Fibrosis (IPF)

Diagnosis of IPF has been confirmed by a respirologist and a high-resolution CT scan within the previous 24 months:

☐ **YES (Please provide a copy of the CT scan)** ☐ **NO**

All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) have been excluded: ☐ **YES** ☐ **NO**

For Patients with Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype (Progressive Fibrosing ILD)

Diagnosis of chronic fibrosing ILD with a progressive phenotype has been confirmed by a specialist with experience in the diagnosis and management of ILD:

☐ **YES - Name of specialist: _____** ☐ **NO**

Treatment Renewal

For All Patients – Post-Treatment Information

Patient's current % predicted Forced Vital Capacity (FVC): _____

Date on which current FVC was obtained: _____

Prescriber Signature and Date:			
Date:		**Prescriber Signature:**	