

Request for Palliative Care Medications

Section 1- Physician Information			Section 2- Patient Information		
First Name	Initial	Last Name	First Name	Initial	Last Name
Street #	Street Name		Ontario Health Insurance Number		
City		Postal Code	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Fax		Telephone	Date of Birth (YYYY/MM/DD)		

Section 3- Patient Diagnosis
Primary Diagnosis: _____ <input type="checkbox"/> This patient has a terminal illness and has chosen outpatient palliative treatment. Life expectancy is less than six months. The medications checked below are requested for symptom control for a maximum period of six months.

Section 4- Requested Medication(s)
<input type="checkbox"/> Diazepam injection or <input type="checkbox"/> Lorazepam injection • <i>for seizure control, anxiety when other dosage forms cannot be used</i> [DIN 00399728 (5mg/mL)] [DIN 02243278 (4mg/mL)]
<input type="checkbox"/> Dimenhydrinate injection • <i>for nausea when other dosage forms cannot be used</i> [DIN 00392537 (50mg/mL)]
<input type="checkbox"/> Furosemide injection • <i>for diuresis when oral route cannot be used</i> [DIN 00527033 (10mg/mL)]
<input type="checkbox"/> Gabapentin • <i>for neuropathic pain after failure of tricyclic antidepressants and opioids if appropriate</i> [DINs 02243446 (100mg); 02243447 (300mg); 02243448 (400mg); plus all interchangeable DINs]
<input type="checkbox"/> Glycopyrrolate injection • <i>for secretion control in the very terminal stage of care</i> [DIN 02039508 (0.2mg/mL)]
<input type="checkbox"/> Hyoscine injection or <input type="checkbox"/> Hyoscine oral (Buscopan®) • <i>for abdominal spasm, pain</i> [DIN 00363839 (20mg/mL)] [DIN 00363812 (10mg)]
<input type="checkbox"/> Methadone • <i>if other opioids fail to control pain or lead to side effects</i> [DINs 02247698 (1mg); 02247699 (5mg); 02247700 (10mg); 02247701 (25mg); 02247694 (1mg/mL); 02241377 (10mg/mL)]
<input type="checkbox"/> Metoclopramide injection • <i>for nausea when oral route cannot be used</i> [DIN 02185431 (5mg/mL)]
<input type="checkbox"/> Midazolam injection • <i>for use in respiratory distress, anxiety</i> [DIN 02240286 (5mg/mL)]
<input type="checkbox"/> Octreotide injection (Sandostatin®) • <i>for bowel obstruction in palliative care</i> [DINs 00839205 (100mcg/mL); 02049392 (200mcg/mL, 5mL); 00839213 (500mcg/mL)]
<input type="checkbox"/> Oxycodone (Supeudol®) • <i>for use when combination oxycodone & acetaminophen cannot be used</i> [DINs 00789739 (5mg); 00443948 (10mg); 02262983 (20mg)]
<input type="checkbox"/> Phenytoin injection • <i>for use in seizure control, when oral dosage forms cannot be used</i> [DIN 00780626 (50mg/mL)]
<input type="checkbox"/> Scopolamine injection • <i>for secretion control in the very terminal stage of care</i> [DINs 00541869 (0.4mg/mL); 00541877 (0.6mg/mL)]
<input type="checkbox"/> Other (drug name, dose, dosage regimen and reason for use): _____ _____

Requests for ICR coverage of other medications may be considered on a case-by-case basis. Please attach a separate written request, including the drug name, dosage regimen, rationale for use, and details of previous medications tried, by following the procedures as outlined in Part VIII of the current ODB Formulary. Requests submitted this way may undergo a longer review process.

Physician signature (Mandatory):	CPSO number:	Date (YYYY/MM/DD):
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