Prairie Cardiac Foundation

TICAGRELOR/CLOPIDOGREL – EXTENDED THERAPY REQUEST FORM:EDS

FAX to Drug Plan: (306) 798-1089

Or CALL: EDS Request Line at (306) 787-8744 or 1-800-667-2549

PATIENT IDENTIFICATION	
Name:	**Health Services Number:**
Address:	**Date of Birth:** ______ / _______ / ______ Day Month Year
	Sex: ☐ Male ☐ Female

DRUG INFORMATION
Drug Requested: ☐ TICAGRELOR 60mg po BID ☐ CLOPIDOGREL 75mg po daily
Total Duration Requested: _______ months total of dual-antiplatelet therapy (up to 3 years maximum).

☐ **I verify that this patient is at high-risk for further cardiac events *(this must be verified or stated on EDS phone-in).***
Other Comments:

PRESCRIBER INFORMATION	
Name:	
Specialization: ☐ Interventional Cardiologist ☐ Cardiac Surgeon ☐ Cardiologist ☐ Internal Medicine Specialist	
Phone Number:	**Fax Number:**