SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

Donepezil, Galantamine and Rivastigmine

Pharmaceutical Services
Department of Health and Community Services
P.O. Box 8700, Confederation Bldg.
St. John's, NL A1B 4J6

Phone: (709) 729-6507
Toll Free Line: 1-888-222-0533
Fax: (709) 729-2851

Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number

Address

Diagnostic Information

Patient is diagnosed with mild to moderate dementia. YES NO

MMSE and FAST scores to be assessed within 60 days of request for coverage.

MMSE Score	Date	FAST Score	Date

FAST STAGE		FUNCTIONAL IMPAIRMENT DUE TO COGNITIVE DEFICIT (NOT PHYSICAL)
4	Mild	IADLs: needs assistance (Instrumental Activities of Daily Living include complex tasks such as managing money and medications, shopping, cooking, driving, housekeeping, using telephone)
5	Moderate	Re-wearing clothes; requires assistance in such basic tasks of daily life as choosing proper clothing. Patient can no longer function independently
6	Moderately Severe	ADLs: needs assistance, especially with dressing and bathing (i.e. unable to bathe properly; inability to handle the mechanics of toileting); eventually experiences urinary and fecal incontinence (Activities of Daily Living include dressing, washing, toileting, feeding, mobility)
7	Severe	Non-verbal, non-ambulatory

Adapted from: Reisberg, B. Functional Assessment Staging (FAST). Psychopharmacology Bulletin 1988;24(4):653-9

Only patients with a MMSE score of 10 to 30 and a FAST score of 4 or 5 are eligible for NLPDP coverage of cholinesterase inhibitors. Initial approval will be for a 6 month period. Renewal of coverage will require reassessment of MMSE and FAST scores.

Cholinesterase Inhibitor

Has this patient been on this cholinesterase inhibitor before? YES since _____ NO

Cholinesterase Inhibitor Requested and Dose

Donepezil (Aricept®)	Dose
Galantamine (Reminyl ER® & generics)	Dose
Rivastigmine (Exelon® and generics)	Dose

Additional Comments:

Prescriber Information/Requested by:

- Prescriber Name: _____ License Number: _____ Phone Number: _____
- Address: _____ Fax Number: _____
- Pharmacist _____ Pharmacy _____
- Signature: _____ Date: _____