



SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
For Initiation of Coverage of Cholinesterase Inhibitor

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
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Address

Diagnostic Information – Complete All

The cause of the patient's dementia is (check as appropriate):
 probable Alzheimer's Disease
 possible Alzheimer's Disease with vascular component
 possible Alzheimer's Disease with Lewy bodies
 possible Alzheimer's Disease with other – specify: _____

MMSE Score _____ Date _____ FAST Score _____ Date _____

FAST Stage	Functional Impairment <i>due to cognitive deficit (NOT PHYSICAL DEFICIT)</i>
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. Assistance is required for independent community living.
6 Severe	ADLs: needs hands-on assistance, especially with dressing and bathing, due to cognitive impairment; eventually experiences urinary and fecal incontinence (Activities of Daily Living include dressing, washing, toileting, feeding, mobility)
7 Very Severe (End Stage)	Non-verbal, non-ambulatory

*Only patients with a FAST score of 4 or 5 are eligible for NLPDP coverage for cholinesterase inhibitors. Initial approval will be for a 6 month period. Renewal of coverage will require reassessment of MMSE and FAST scores.
 Adapted from: Reisberg, B. Functional Assessment Staging. Psychopharmacology Bulletin. 1988.*

Cholinesterase Inhibitor

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

Is this a switch to a different agent due to intolerance? YES NO

If yes, please describe the intolerance:

Cholinesterase inhibitor requested and starting dosage:

<input type="checkbox"/> Donepezil (Aricept®)	Dosage: _____
<input type="checkbox"/> Rivastigmine (Exelon® and generics)	Dosage: _____
<input type="checkbox"/> Galantamine (Reminyl ER® & generics)	Dosage: _____

Prescriber Information/Requested by:

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