SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

For Continuation 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

Address

MMSE and FAST (Complete Both)

MMSE Score_____ Date _____ FAST Score_____ Date _____

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

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. 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.*
Adapted from: Reisberg, B. Functional Assessment Staging. Psychopharmacology Bulletin. 1988.

Evidence of Benefit

Is the patient benefiting from this drug? ☐ YES or ☐ NO	*Only for initial re-assessment. Not required for subsequent annual re-assessments.* Please describe: ** benefit can be based on caregiver report or cognitive testing; consider cognitive, functional, behavioral, social and leisure domains*
When is it time to consider discontinuing the cholinesterase inhibitor?	• If MMSE <10 OR FAST ≥6 (not eligible for coverage) OR • there is no initial improvement after 3-6 months of drug therapy OR • the patient has a rapid decline in cognitive or functional symptoms OR • rapid decline in MMSE (>3points in 6 months) or FAST

Cholinesterase Inhibitor

Cholinesterase inhibitor requested and starting/continuing dosage (including titration):

□ Donepezil (Aricept®) Dosage: _____
□ Rivastigmine (Exelon® & generics) Dosage: _____
□ Galantamine (Reminyl ER® & generics) Dosage: _____

Prescriber Information/Requested by:

☐ Prescriber Name: _____ License Number: _____ Phone Number: _____

☐ Address: _____ Fax Number: _____

☐ Pharmacist _____ Pharmacy _____

☐ Prescriber: _____ Date: _____