Print Form

Health PEI

SPECIAL AUTHORIZATION REQUEST

ALZHEIMER'S DISEASE

Fax requests to (902) 368-4905 **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)		PATIENT (FAMILY) NAME	PATIENT (GIVEN) NAME(S)
DATE OF BIRTH (YYYY/MM/DD)	PATIENT WEIGHT (kg)	PATIENT'S MAILING ADDRESS	

SECTION 2 – PRESCRIBER INFORMATION

NAME AND MAILING ADDRESS	APPLICATION DATE YYYY / MM / DD
	PRESCRIBER'S TELEPHONE # AREA CODE
	PRESCRIBER'S FAX # AREA CODE

SECTION 3 – MEDICATION DETAIL INFORMATION

REQUESTED DRUG (PLEASE CHECK ONE)	DOSAGE AND FREQUENCY
☐ **Donepezil (Aricept)** ☐ **Galantamine (Reminyl)** ☐ **Rivastigmine (Exelon)**	

CAUSE OF PATIENT'S DEMENTIA (check relevant boxes below):

☐ Probable Alzheimer's disease;

☐ Probable Alzheimer's disease with vascular component;

☐ Probable Alzheimer's disease with Lewy bodies;

☐ Probable Alzheimer's disease with other (please specify);

- Current MMSE score is (must be within 90-days of application): _____ Date: _____

- Previous MMSE score was: _____ Date: _____

- Patients less than 65 years of age will require a written consultation from a neurologist or geriatrician supporting the diagnosis and treatment. A copy of the consultation must be included with the Special Authorization Request.

TYPE OF COVERAGE REQUESTED (check relevant boxes below):

☐ Request for an initial 90-day trial of a cholinesterase inhibitor.

☐ Request for a second 90-day trial using a second cholinesterase inhibitor.

- Please identify the previous cholinesterase inhibitor: _____ Date started: _____

- Reason a previous cholinesterase inhibitor was discontinued:

☐ Important deterioration in dementia symptoms ☐ Drug interactions ☐ Gastrointestinal side-effects ☐ Drug-disease interactions ☐ Syncope

☐ Sleep disturbances ☐ Delirium ☐ Other (specify): _____

OR

☐ Request for continued coverage of a cholinesterase inhibitor. Date started: _____

PEI Pharmacare may request additional documentation to support this Special Authorization Request. Personal information on this form is collected under section 31(c) of Prince Edward Island's Freedom of Information & Protection of Privacy (FOIPP) Act as it relates directly to and is necessary for providing services under the PEI High-Cost Drugs Program.

If you have any questions about this collection of personal information, you may contact the program office at 902-368-4947 or at the address at the top of the form.

_____

PRESCRIBER SIGNATURE (REQUIRED) **DATE**

11HPE15-30346

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.
APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES.