NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

REQUEST FOR 1ST CHOLINESTERASE INHIBITOR

(FOR INITIAL 90 DAYS COVERAGE)

Please provide the following to support your request for insured coverage of the first cholinesterase inhibitor for an initial period of 90 days.

PATIENT INFORMATION			
PATIENT'S SURNAME	PATIENT'S GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH
PATIENT'S ADDRESS			

DIAGNOSTIC INFORMATION

The patient has a confirmed memory problem **and**: MMSE score: _______ FAST score: ________________

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): ______________________________

TARGET SYMPTOMS ESTABLISHED

List the 3 target symptoms established:

1. ______________________________

2. ______________________________

3. ______________________________

CHOLINESTERASE INHIBITOR

Has this patient been on this cholinesterase inhibitor before?

☐ YES since ______________________ ☐ NO ______________________

Cholinesterase inhibitor requested and starting dosage:

☐ Donepezil (Aricept®) – Dosage: ________ mg ________ times daily

☐ Galantamine (Reminyl ER®) – Dosage: ________ mg ________ times daily

☐ Rivastigmine (Exelon®) – Dosage: ________ mg ________ times daily

Check for tolerance within 2 weeks of starting the above cholinesterase inhibitor.

PHYSICIAN'S NAME & ADDRESS	
CPSNS #: ________	PHYSICIAN'S SIGNATURE ________ DATE ________

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026.

08/2007

Please Return Form To: Nova Scotia Pharmacare Department, P.O. Box 500, Halifax, NS B3J 2S1 FAX: (902) 468-9402