NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

REQUEST TO SWITCH TO A 2ND CHOLINESTERASE INHIBITOR

(FOR INITIAL 90 DAYS COVERAGE)

Please provide the following to support your request for insured coverage of the second 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

REASON FOR DISCONTINUING FIRST CHOLINESTERASE INHIBITOR

Cholinesterase inhibitor ______________________________

Reason for discontinuing:

- ☐ important deterioration in target symptoms
- ☐ gastrointestinal side effects
- ☐ syncope
- ☐ delirium
- ☐ other (specify): ______________________________
- ☐ drug interactions
- ☐ drug-disease interactions
- ☐ sleep disturbances

CHOLINESTERASE INHIBITOR

Second 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.

TARGET SYMPTOMS ESTABLISHED

If new target symptoms are established, please specify:

1. ______________________________
2. ______________________________
3. ______________________________

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