ALBERTA BLUE CROSS®

DONEPEZIL/GALANTAMINE/RIVASTIGMINE SPECIAL AUTHORIZATION REQUEST FORM

Please complete ALL sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT LAST NAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other REGISTRATION NO.
STREET ADDRESS			
CITY , PROVINCE			PHONE: FAX:
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Criteria for Coverage of DONEPEZIL, GALANTAMINE, RIVASTIGMINE

For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26 and/or an InterRAI-Cognitive Performance Scale score between 1-4.

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination.

Special authorization coverage may be granted for a maximum of 24 months per request.

For each request, an updated MMSE score or InterRAI-Cognitive Performance Scale score and the date on which the exam was administered must be provided.

Renewal requests may be considered for patients where the updated MMSE score is 10 or higher or the InterRAI-Cognitive Performance Scale is 4 or lower while on this drug.

Note:

- an MMSE score below 10 or an InterRAI-Cognitive Performance Scale score greater than 4 at any time will result in discontinuation of coverage.

PLEASE COMPLETE ALL SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

Indicate which drug is requested:

- ☐ **Donepezil**
- ☐ **Galantamine**
- ☐ **Rivastigmine**

Please confirm the diagnosis for which this drug is requested:

For the treatment of:

- ☐ Dementia of the Alzheimer's Type
- ☐ other, please specify: _____

Please provide a **current MMSE or InterRAI-Cognitive Performance Scale score*** and the **date** the exam was administered:

MMSE Score: _____ Date of exam: _____

InterRAI-Cognitive Performance Scale Score: _____ Date of exam: _____

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas