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 (YYYY/MM/DD)	ALBERTA PERSONAL HEALTH NUMBER				
STREET ADDRESS	CITY	PROV	POSTAL CODE		ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION		
PRESCRIBER LAST NAME FIRST NAME INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
	☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
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 (e.g. Aricept)**
☐ **Galantamine (e.g. Reminyl ER)**
☐ **Rivastigmine (e.g. Exelon)**

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

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

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