NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Renewal of a Cholinesterase Inhibitor

Please provide the following to support your request for *renewal* of a cholinesterase inhibitor

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

CHOLINESTERASE INHIBITOR

Cholinesterase inhibitor requested and starting dosage

☐ Donepezil (Aricept) Dosage: _____

☐ Galantamine (Reminyl ER and generics) Dosage: _____

☐ Rivastigmine (Exelon and generics) Dosage: _____

MMSE & FAST (COMPLETE BOTH)

MMSE Score _____ Date _____ FAST Score _____ Date _____

FAST Stage	**Functional Impairment *due to cognitive deficit (NOT PHYSICAL DEFICIT)***
4 Mild	IADLs: needs assistance (Instrumental Activities of Daily Living include complex tasks such as managing money and medications, shopping, cooking, driving, housekeeping, using telephone)
5 Moderate	Re-wearing clothes; requires assistance in such basic tasks of daily life as choosing proper clothing. Assistance is required for independent community living
6 Severe	ADLs: needs hands-on assistance, especially with dressing and bathing, due to cognitive impairment; eventually experiences urinary and fecal incontinence (Activities of Daily Living include dressing, washing, toileting, feeding, mobility)
7 Very Severe (End Stage)	Non-verbal, non-ambulatory

*Only patients with a FAST score of **4 or 5** are eligible for coverage for cholinesterase inhibitors.*
Adapted from: Reisberg, B. Functional Assessment Staging. Psychopharmacology Bulletin. 1988.

EVIDENCE OF BENEFIT

Is the patient benefitting from this drug? ☐ Yes or ☐ No	Only for initial re-assessment. Not required for subsequent annual re-assessments. **Please describe:** ** Benefit can be based on caregiver report or cognitive testing; consider cognitive, functional, behavioural, social and leisure domains*
When is it time to consider discontinuing the cholinesterase inhibitor?	• If MMSE <10 OR FAST ≥6 (not eligible for coverage) OR • there is no initial improvement after 3-6 months of drug therapy OR • the patient has a rapid decline in cognitive or functional symptoms OR • rapid decline in MMSE (>3points in 6 months) or FAST

PRESCRIBER NAME & ADDRESS:

_____ **LICENCE #**

_____ **PRESCRIBER SIGNATURE**

_____ **DATE**

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

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1
Fax: (902) 496-4440

11/2016

NOVA SCOTIA