

Strictly Confidential
DEMENTIA of the ALZHEIMER'S TYPE Prior Authorization Form

Fax completed form to 1-902-481-7114
Or Mail to: MHCSI, 201 Brownlow Avenue, Unit 20
Dartmouth, NS B3B 1W2

This form must be completed **IN FULL** and submitted to MHCSI to permit authorization for coverage of medications indicated for management of dementia of the Alzheimer's type.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____
(PLEASE PRINT)

ADDRESS: _____
(STREET/MAILBOX) (CITY)

(PROVINCE) (POSTAL CODE)

MHCSI CARD NUMBER: _____ / _____
(GROUP #) (CERTIFICATE OR CLIENT#)

I hereby authorize my physician/nurse practitioner and/or pharmacist to provide the information necessary to complete this form on my behalf for request of coverage of medication for dementia of the Alzheimer's type by my drug plan.

SIGNATURE: _____ DATE: _____

CRITERIA FOR COVERAGE

CHOLINESTERASE INHIBITORS

Patients are eligible for coverage of approved medications if they meet the following criteria:

1. The patient has been diagnosed with probable Alzheimer's Disease (AD) or possible AD with vascular component, with Lewy bodies or other (as specified) by a physician trained in dementia and cholinesterase inhibitor (ChEI) therapy.
2. The Mini-Mental State Exam (MMSE) score is 10 to 30.
3. The Functional Assessment Staging (FAST) score is 4 to 5.
4. Three target symptoms have been established, chosen from any of the four domains. *

* **Examples of Target Symptoms in Each of the Four Domains include:**

- **Cognitive:** the patient may have difficulty following a conversation, finding words, following directions, working the remote control, dialing a familiar phone number, remembering family names, finding way around familiar places etc.
- **Behaviour:** the patient may be irritable more than once a day, restless (pacing, fidgeting, repeating activities), have difficulty participating in daily conversations, have delusions, fluctuations in memory, irregular sleep patterns etc.
- **Function:** the patient may have difficulty doing own banking (machine or otherwise), cooking, grooming, dressing, and bathing independently, doing light house work (OR any (IADL) Instrumental Activities of Daily Living) etc.
- **Leisure/Social:** the patient may have difficulty participating in hobbies (e.g. card games), social gatherings and large groups (e.g. hiding in a corner), reading a novel, enjoying gardening, watching television, walking independently etc.

MEMANTINE (EBIXA & GENERIC BRANDS)

Patients are eligible for coverage of Memantine if they meet the following criteria:

1. First-line monotherapy in moderately severe (MMSE 10-14) Alzheimer's Disease patients who are newly diagnosed (i.e. no previous treatment) or who have discontinued treatment with a cholinesterase inhibitor (ChEI) due to lack of efficacy or tolerability
2. First-line therapy for severe (MMSE < or = 10) Alzheimer's Disease patients
3. Adjunctive treatment in moderately severe (MMSE 10-14) to severe (MMSE < or = 10) Alzheimer's Disease patients already stabilized on donepezil or other cholinesterase inhibitors

continued on next page

CONDITIONS OF APPROVAL

Initial authorizations for new to therapy patients will be approved for one year.

Subsequent renewals and approvals for existing patients on **ChEI's** will be approved for one year with physician documentation on a PA form of a MMSE score of 10 to 30, a FAST score of 4 to 5, and stabilization of, or improvement in, at least one target symptom.

For existing patients on **Memantine**, approval will be for one year with physician documentation on a PA form demonstrating stabilization of, or improvement in, at least one target symptom and any other relevant clinical information. **For Memantine patients on an adjunctive Cholinesterase Inhibitor (ChEI)**, approval will be for one year with physician documentation on the PA form as for **Memantine** renewal.

Coverage for a second ChEI will be approved with physician documentation on a PA form demonstrating: the patient has previously taken no more than ONE ChEI, the reason for discontinuing the first ChEI, and any changes in target symptoms. Coverage for the second ChEI is provided in the same manner as the first ChEI.

**TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER (NP)
and/or PHARMACIST IN CONSULTATION WITH THE PHYSICIAN/NURSE PRACTITIONER**

*Dear Doctor/Nurse Practitioner/Pharmacist: We appreciate you providing information on this patient's medical condition and medication history which is required by the drug plan sponsor for authorization of claims for dementia of the Alzheimer's Type. Please complete the following sections of this form **IN FULL**. Any costs incurred in the completion of this form are the responsibility of the patient.*

Medication Requested -generic brand may be used where available		
Drug Name	Strength	DIN
Aricept (donepezil)	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg	<input type="checkbox"/> 02232043 <input type="checkbox"/> 02232044
Ebixa (memantine)	<input type="checkbox"/> 10mg	<input type="checkbox"/> 02260638
Exelon (rivastigmine)	<input type="checkbox"/> 1.5mg <input type="checkbox"/> 3mg <input type="checkbox"/> 4.5mg <input type="checkbox"/> 6mg <input type="checkbox"/> 2mg/ml solution	<input type="checkbox"/> 02242115 <input type="checkbox"/> 02242116 <input type="checkbox"/> 02242117 <input type="checkbox"/> 02242118 <input type="checkbox"/> 02245240
Exelon Patch (rivastigmine)	<input type="checkbox"/> 5 (4.6mg/24hr) <input type="checkbox"/> 10 (9.5mg/25hr)	<input type="checkbox"/> 02302845 <input type="checkbox"/> 02302853
Reminyl ER (galantamine)	<input type="checkbox"/> 8mg <input type="checkbox"/> 16mg <input type="checkbox"/> 24mg	<input type="checkbox"/> 02266717 <input type="checkbox"/> 02266725 <input type="checkbox"/> 02266733
Generic Brand –Name & Strength <input type="checkbox"/>		DIN <input type="checkbox"/>

continued on next page

TREATMENT REGIMEN			
<input type="checkbox"/> first time use	<input type="checkbox"/> continuation of therapy	<input type="checkbox"/> change in therapy	<input type="checkbox"/> adjunctive therapy to Memantine
If this is a change in therapy, please indicate the previous medication(s) tried and why the patient is discontinuing treatment:			
For Memantine - Please confirm the indication for which this/these drug(s) is/are requested:			
<input type="checkbox"/> First-line monotherapy in moderately severe (MMSE 10-14) Alzheimer's Disease patients: <ul style="list-style-type: none"> <input type="checkbox"/> newly diagnosed (i.e. no previous treatment) <input type="checkbox"/> who have discontinued treatment with a ChEI due to lack of efficacy or tolerability <input type="checkbox"/> First-line therapy for severe (MMSE < or = 10) Alzheimer's Disease patients <input type="checkbox"/> Adjunctive treatment in moderately severe (MMSE 10-14) to severe (MMSE < or = 10) Alzheimer's Disease patients already stabilized on donepezil or other cholinesterase inhibitors			
MONITORING			
Recent MMSE score _____		Date of exam _____	
Recent FAST score _____		Date of exam _____	
Note: MMSE and FAST scores are required initially, then yearly thereafter, and again for change in therapy			

Describe THREE Established Target Symptoms from any of the Four Domains *. If this is an application for renewal, describe and indicate stabilization (S) or improvement (I). If this is an application for a change in therapy, describe the changes in target symptoms.

(S) __ (I) __ Cognitive:

(S) __ (I) __ Behaviour:

(S) __ (I) __ Function:

(S) __ (I) __ Leisure/Social:

Other supporting information (ADAS-cog, CIBIC-plus, MOCHA, etc.):

Physician/NP Name/Signature:		Phone:	Date:
Pharmacist Name/Signature:		Store # & Location/ Phone # :	Date:
OFFICE USE ONLY			
Approval <input type="checkbox"/> Accepted <input type="checkbox"/> Declined	Date		Quantity
	Approved by		and/or End date
Extension possible <input type="checkbox"/> Yes <input type="checkbox"/> No			