

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

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 prescriber 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 MEDICAL PRACTITIONER

*Dear Prescribing Medical Practitioner: 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, MOCA, etc.):

Prescriber 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	Processing Number	
Extension possible <input type="checkbox"/> Yes <input type="checkbox"/> No					