BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

CHOLINESTERASE INHIBITORS
INITIAL COVERAGE (6 MONTHS)

ALZHEIMER'S DRUG THERAPY INITIATIVE

Fax requests to 1 800 609-4884 (toll free)
OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4

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Forms with information missing will be returned for completion.

INITIAL ELIGIBILITY CRITERIA: Diagnosis of Alzheimer's Disease with SMMSE of ≥ 10 to ≤ 26 and Global Deterioration Scale ≥ 4 to ≤ 6

For Reference Only.
Please See Form
HLTH 5465

SECTION 1 – PRESCRIBER INFORMATION

NAME & MAILING ADDRESS ☐ MAIL CONFIRMATION	APPLICATION DATE YYYY MM DD	PRESCRIBER'S TEL # AREA CODE
	PRESCRIBER'S COLLEGE ID #	PRESCRIBER'S FAX # AREA CODE

SECTION 2 – PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN)	PATIENT (FAMILY) NAME
DATE OF BIRTH (YYYY / MM / DD)	PATIENT (GIVEN) NAME(S)

SECTION 3 – MEDICATION REQUESTED (MONTHLY FILLS)

	STARTING DOSE	TITRATION AS TOLERATED	EFFECTIVE RANGE
☐ **DONEPEZIL**	5 mg daily (2.5 mg if frail) for 4 to 6 weeks	increase by 5 mg	5 to 10 mg daily
☐ **GALANTAMINE**	8 mg ER daily for 4 to 6 weeks	increase by 8 mg	16 to 24 mg daily
☐ **RIVASTIGMINE** (divided dose)	1.5 mg twice daily for 2 to 4 weeks	increase by 1.5 to 3 mg twice daily	6 to 12 mg daily
☐ **RIVASTIGMINE** (patch)	1 patch (5 cm^2/9 mg) once daily for 4 to 6 weeks	increase to 1 patch (10 cm^2/18 mg) once daily	1 patch (5 cm^2/9 mg) to 1 patch (10 cm^2/18 mg) once daily

SECTION 4 – CLINICAL INFORMATION (ALL THREE SECTIONS MUST BE COMPLETED)

PRESUMPTIVE DIAGNOSIS	**SMMSE**	**GDS** (GLOBAL DETERIORATION SCALE)
☐ ALZHEIMER'S DISEASE (AD) ☐ AD WITH PARKINSONIAN FEATURES (LEWY BODIES) ☐ AD WITH VASCULAR COMPONENT ☐ AD WITH OTHER (SPECIFY):	______ ≥10 TO ≤26 **OR:** ☐ UNABLE TO COMPLETE BECAUSE OF FUNCTIONAL ILLITERACY)	______ ≥4 TO ≤6

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I have discussed with the patient the purpose of the release of the patient's information to PharmaCare to obtain Special Authority for prescription benefit and for the purposes set out above.

Signature of Prescriber (Mandatory) ______________________ Patient Signature (Optional) ______________________

PharmaCare may request additional documentation to support this Special Authority request.

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE
	DURATION OF COVERAGE
	TERMINATION DATE

BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

CHOLINESTERASE INHIBITORS
RENEWAL/SWITCHING COVERAGE (6 MONTHS)

ALZHEIMER'S DRUG THERAPY INITIATIVE

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☐ **RENEWAL**
Eligibility criteria: Diagnosis of Alzheimer's Disease with SMMSE $\geq$10, GDS 4 to 6, Overall Patient Assessment Rating of positive responder or indeterminate responder.

☐ **SWITCHING FOR LACK OF EFFECTIVENESS**
Eligibility criteria: Diagnosis of Alzheimer's Disease with SMMSE $\geq$10, GDS 4 to 6.

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SECTION 4 – SWITCHING FOR LACK OF EFFECTIVENESS (IF APPLICABLE)

CHOLINESTERASE INHIBITOR BEING DISCONTINUED	DATE TREATMENT STOPPED (YYYY / MM / DD)	DOSAGE

TO PAGE 2 →

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STATUS	EFFECTIVE DATE
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CHOLINESTERASE INHIBITORS RENEWAL/SWITCHING COVERAGE (6 MONTHS)

PATIENT NAME	PHN	DATE OF BIRTH (YYYY / MM / DD)

SECTION 5 – PATIENT ASSESSMENT FOR RENEWING OR SWITCHING FOR LACK OF EFFECTIVENESS

STEP 1	PREVIOUS SMMSE SCORE (WITHIN LAST 4-6 MONTHS)	**CURRENT SMMSE SCORE**	DIFFERENCE	☐ UNABLE TO COMPLETE SMMSE BECAUSE OF FUNCTIONAL ILLITERACY	**CURRENT GDS STAGE**

STEP 2

ASSESS THE CHANGE IN ABILITY OVER THE LAST SIX MONTHS.

COGNITION	A. MEMORY, REASONING AND PERCEPTION (E.G. NAMES, TASKS, SMMSE)	______	(+1 = IMPROVED, 0 = NO CHANGE, -1 = WORSE)
FUNCTION	B. INSTRUMENTS OF DAILY LIVING (E.G. TELEPHONE, SHOPPING, MEAL PREPARATION)	______	(+1 = IMPROVED, 0 = NO CHANGE, -1 = WORSE)
	C. BASIC ACTIVITIES OF DAILY LIVING (E.G. BATHING, DRESSING, HYGIENE AND TOILETING)	______	(+1 = IMPROVED, 0 = NO CHANGE, -1 = WORSE)
BEHAVIOUR	D. NEUROPSYCHIATRIC SYMPTOMS (E.G. AGITATION, DELUSIONS, HALLUCINATION, APATHY)	______	(+1 = IMPROVED, 0 = NO CHANGE, -1 = WORSE)
	TOTAL SCORE (A+B+C+D):	______	

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STEP 3

TOTAL SCORE		OVERALL PATIENT ASSESSMENT RATING		RECOMMENDATION
+4	→ **CLINICAL JUDGMENT** →	☐ VERY MUCH IMPROVED	POSITIVE RESPONDER	CONTINUE TREATMENT; RE-EVALUATE PATIENT EVERY 6 MONTHS
+3 OR +2		☐ MUCH IMPROVED		
+1		☐ MINIMALLY IMPROVED		
0		☐ NO CHANGE	INDETERMINATE RESPONDER	CONTINUE TREATMENT; RE-EVALUATE PATIENT EVERY 6 MONTHS (CONSIDER SWITCHING CHOLINESTERASE INHIBITOR).
-1		☐ MINIMALLY WORSE		
-2 OR -3		☐ MUCH WORSE	NON-RESPONDER	STOP TREATMENT OF CURRENT CHOLINESTERASE INHIBITOR (CONSIDER SWITCHING CHOLINESTERASE INHIBITOR).
-4		☐ VERY MUCH WORSE		

ELIGIBILITY CRITERIA: PRESUMPTIVE DIAGNOSIS OF ALZHEIMER'S DISEASE WITH SMMSE $\geq$ 10, GDS 4 TO 6, OVERALL PATIENT ASSESSMENT RATING OF POSITIVE RESPONDER OR INDETERMINATE RESPONDER. PLEASE NOTE SMMSE SCORES OVER 26 INDICATE POSITIVE RESPONDER.

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Patient Signature (Optional)

SUPPLEMENTARY INFORMATION (required for payment of MSP fee item 97002)

To be used by BC researchers in a study to improve the care and treatment of individuals affected by Alzheimer's disease.

PATIENT			
LIVES ALONE	☐ YES	☐ NO	HEIGHT: ______ CM OR ______ IN
RESIDES IN A FACILITY WHERE MEDICAL CARE IS PROVIDED	☐ YES	☐ NO	WEIGHT: ______ KG OR ______ LBS *IF UNABLE TO MEASURE, PLEASE PROVIDE ESTIMATE*

BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

CHOLINESTERASE INHIBITORS SWITCHING FOR TOLERABILITY

ALZHEIMER'S DRUG THERAPY INITIATIVE

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SECTION 4 – SWITCHING FOR LACK OF TOLERABILITY

1. Stop current cholinesterase inhibitor
2. Allow washout period of 2 days for galantamine and rivastigmine, or 5 to 7 days for donepezil
3. Start new cholinesterase inhibitor using the same titration schedule as new starts

CHOLINESTERASE INHIBITOR BEING DISCONTINUED	DATE TREATMENT STOPPED (YYYY / MM / DD)	DOSAGE
SIDE EFFECTS (PLEASE SPECIFY)		

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