New Nouveau Brunswick

New Brunswick Drug Plans / Régimes de médicaments du Nouveau-Brunswick

NEW BRUNSWICK DRUG PLANS
FIRST REQUEST FOR CHOLINESTERASE INHIBITOR
SPECIAL AUTHORIZATION REQUEST FORM

NBAD - 1

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ MI: _____

Plan ID or Medicare Number: _____ Date of Birth (DD/MM/YYYY): _____

Street Address: _____

P.O. Box: _____ City: _____ Postal Code: _____

DIAGNOSTIC INFORMATION - COMPLETE ALL

The cause of the patient's dementia is (check as appropriate):

☐ probable Alzheimer's Disease

☐ possible Alzheimer's Disease with vascular component

☐ possible Alzheimer's Disease with Lewy bodies

☐ possible Alzheimer's Disease with other - Specify: _____

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.

CHOLINESTERASE INHIBITOR

Has this patient been on a cholinesterase inhibitor before? ☐ YES since _____ ☐ NO

Is this a switch to a different agent due to intolerance? ☐ YES ☐ NO

If yes, please describe the intolerance: _____

A switch to a second cholinesterase inhibitor agent will only be considered for reimbursement during the first six-month approval period.

Cholinesterase inhibitor requested and starting dosage:

☐ Donepezil (Aricept® and generic products) Dosage: _____

☐ Galantamine (Reminyl ER® and generic products) Dosage: _____

☐ Rivastigmine (Exelon® and generic products) Dosage: _____

REQUESTOR INFORMATION

Requestor Name: _____

Requestor Address: _____

_____

Fax Number: _____

License Number (e.g. CPSNB, NANB, NBCP, etc.): _____

Requestor Signature: _____

Date (DD/MM/YYYY): _____

PLEASE RETURN COMPLETED FORM TO:

Special Authorization Unit,
New Brunswick Drug Plans
P.O. Box 690
644 Main Street
Moncton, NB E1C 8M7

Inquiry Line: 1-800-332-3691
Local Fax: 506-867-4872
Toll Free Fax: 1-888-455-8322