



Aricept/Exelon/Reminyl Exception Drug Status Application

Please see the Formulary for detailed criteria.

PATIENT NAME: _____

ADDRESS: _____

HSN: _____ DATE OF BIRTH _____

Please complete all sections to allow this request to be processed.

1. Drug requested (check one): Aricept or Exelon or Reminyl
2. This patient is (check one): **not currently taking** the requested medication (new patient)
 currently taking the requested medication (existing patient) or **renewal**
 switching from one cholinesterase inhibitor to another
3. Diagnosed with probable Alzheimer disease as per DSM-IV criteria. Yes No
4. Recent+ MMSE score* _____ date _____
5. FAQ score* _____ date _____
6. Drugs with anticholinergic activity++ are to be discontinued at least 14 days before the MMSE and FAQ are administered and are not to be used concurrently with Aricept, Exelon or Reminyl.

List all medications the patient is currently taking or attach a list.

this patient is not taking other medications

PHYSICIAN NAME: _____ PHONE #: _____

ADDRESS: _____ FAX #: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

- *New patients who meet the criteria will be approved for a 3 month treatment period (a patient **intolerant** to one drug and switching to a second will be considered a "new" patient). For renewal after the 3 month period, patients must exhibit an improvement from the initial MMSE or FAQ for coverage to continue (refer to the Formulary for complete information).*
- *Existing patients who meet the criteria will be approved for a 6 month treatment period. For renewal after the 6 month period, patients must not decline in both the MMSE and FAQ (refer to the Formulary for complete information).*
- *Coverage will not be considered for patients who have failed on other drugs in this class.*
- *Aricept, Exelon or Reminyl do not need to be discontinued prior to MMSE or FAQ testing.*
- *MMSE must be between 10-26 to be eligible for coverage.*
- *Patients who do not meet the criteria for renewal can be re-evaluated to confirm deterioration. This re-evaluation must occur within the next 3 months. If upon re-evaluation the patient meets the criteria coverage will be backdated to the last expiry date.*

Completed forms can be faxed to 1-306-798-1089

Or mailed to: Saskatchewan Health - Drug Plan & Extended Benefits Branch
2nd Floor, 3475 Albert Street, REGINA, Saskatchewan S4S 6X6

+ recent MMSE score is that which is within 60 days of the initial application or no greater than 1 month before the current EDS expiry date.
 * only the MMSE & FAQ scores are required. It is not necessary to include the actual tests with this application.
 ++ for a list of drugs with anticholinergic effects see the SFC Quarterly Update bulletin (#86) April 2001.