

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Rivastigmine**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- The patient has been diagnosed with dementia  
**and**  
 The patient has experienced intolerable nausea and/or vomiting from donepezil tablets

**CONTINUATION**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- The treatment remains appropriate  
**and**  
 The patient has demonstrated a significant and sustained benefit from treatment

I confirm that the above details are correct:

Signed: ..... Date: .....