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

HOSPITAL

I confirm that the above details are correct:

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