

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 is contraindicated to or has experienced intolerable side effects 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: