BRITISH COLUMBIA | Ministry of Health

# FREQUENT DISPENSING AUTHORIZATION

This form is a notification only. It is to let prescribers know that a pharmacist has initiated frequent dispensing for a patient.
Pharmacists should fax the completed form to every prescriber that needs to be notified.
Prescribers do not need to respond unless they disagree, in which case they fill out the Prescriber Response section.
This form is not required for daily dispensing (which must always be authorized by the prescriber), nor if the prescriber has authorized 2 to 27 days' supply in writing.
This form is valid for one year from the date the patient signs the Patient Declaration.

## PATIENT INFORMATION

| Patient Last Name | Patient First Name | Personal Health Number (PHN) |
|---|---|---|
| | | |

Frequency of Dispensing

◯ Weekly ◯ Biweekly ◯ Other (specify):

## PHARMACY INFORMATION

| Name of Pharmacy | Fax Number (including area code) |
|---|---|
| | |

## RATIONALE FOR FREQUENT DISPENSING

To qualify for coverage of additional dispensing fees for more frequent dispensing of a drug(s), a patient must be unable to manage their drug therapy independently. The patient must exhibit one or more of the following (please select all that apply; you must select at least one):

- ☐ Cognitive impairment
- ☐ History of abuse or poor compliance
- ☐ No support structure (to assist with administration of drug therapy)
- ☐ Risk of dependence
- ☐ Susceptible to theft or loss of belongings
- ☐ Complex medication regime
- ☐ Physical or mental disability
- ☐ Literacy issues
- ☐ Language issues
- ☐ Non-compliance or misuse is suspected

Check box if applicable:

☐ 2-27–day dispensing verbally authorized by prescriber

Prescriber Name: _____

## PATIENT DECLARATION — MUST BE SIGNED

I declare that I need PharmaCare coverage of additional dispensing fees for frequent dispensing of my medications for the reason(s) shown above. I also provide consent to notify my prescriber(s). I hereby consent to the release of this information to the Ministry of Health and/or Health Insurance BC. The information will be collected, used and disclosed as permitted under the *Pharmaceutical Services Act* and the *Freedom of Information and Protection of Privacy Act*. I understand that my PharmaNet records are subject to routine audits by the Ministry of Health to ensure compliance with the Frequency of Dispensing Policy.

Personal information on this form is protected from unauthorized collection, use and disclosure in accordance with the *Pharmaceutical Services Act* and the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100.

☐ I am the legal representative of the patient for whom the prescription is written. The nature of the legal relationship is: _____
*nature of legal relationship to patient*

_____ _____
*signature of patient or representative (required)* *date signed (dd / mm / yyyy)*

Only the patient or their legal representative may sign. It is not acceptable for a caregiver who is not the patient's legal representative to sign the declaration on their behalf.

## PHARMACIST DECLARATION OF PRESCRIBER NOTIFICATION

I declare that I have notified these prescriber(s) by fax:

| Prescriber Name | Date Initialed (dd / mm / yyyy) | Pharmacist Initials | Prescriber Name | Date Initialed (dd / mm / yyyy) | Pharmacist Initials |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

In the pharmacist's opinion, this patient meets the above criteria for frequent dispensing. Prescribers do not need to take any action unless they disagree with the frequent dispensing decision. Note that if you take no action, it does not imply that you agree that the patient meets the clinical criteria indicated above.

## PRESCRIBER RESPONSE

Complete this section only if you disagree with frequent dispensing for this patient.

☐ I disagree with frequent dispensing for this patient as shown above.

_____ _____ _____
*signature of prescriber* *date signed (dd / mm / yyyy)* *prescriber pract/college ID #*

**If you completed this section, you will need to fax this form to the pharmacy indicated above and to Health Insurance BC at (250) 405-3599**

Completed copies of this form must be retained on file in the pharmacy in accordance with the record keeping requirements established in the Pharmacy Operations and Drug Scheduling Act, Health Professions Act and any relevant College of Pharmacists of British Columbia Professional Practice Policies.

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