



This form must be completed each time a pharmacist recommends and dispenses a Schedule 2 or Schedule 3 product, or an unscheduled product that is covered by Plan W, to a Plan W beneficiary, as per the *Pharmaceutical Services Act* section 16(2).

This form is not needed if the recommendation is documented on the Minor Ailments and Contraception Services (MACS) form; however, the claim must be entered in PharmaNet for the medication to be covered under Plan W.

This form is not needed for insulins. Insulins can be dispensed and the claim entered in PharmaNet without a prescription or this form.

Retain this form in accordance with record-keeping requirements.

PATIENT AND DRUG INFORMATION

Name of Patient	Birthdate (DD / MM / YYYY)	Personal Health Number (BC Services Card)
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Attach drug labels here. If there are several, please number each label "Drug 1", "Drug 2" etc., to correspond with the entries for indications and follow-up.

Labels should include:

- Patient name
- Prescription number
- Product name
- DIN/NPN
- Manufacturer
- Product strength
- Quantity dispensed
- Directions
- Date dispensed

	Drug indication(s) for patient	Follow-up date and method, if needed
Drug 1		
Drug 2		
Drug 3		

PATIENT DECLARATION (If patient signature is not possible, see BOX A in Pharmacist Declaration)

I declare that the medication(s) dispensed to me and paid for through PharmaCare Plan W will be used personally by me. I understand that personal information on this form is collected by the Ministry of Health under s.22 of the *Pharmaceutical Services Act* for the purpose of assessing my First Nations Health Benefits (Plan W) claim.

Signature of Patient (or Patient's Personal Representative*)	Print Name of Patient (or Patient's Personal Representative*)	
	Date Signed (DD / MM / YYYY)	* personal representative means a person having the authority under the common law or an enactment to make decisions on behalf of a beneficiary

PHARMACIST DECLARATION

I declare that the drug recommendation(s) is/are based on appropriate assessment of the patient and that the patient has received eligible Schedule 2, Schedule 3, or unscheduled product(s) through PharmaCare Plan W. I declare that the patient has received full consultation on each drug listed above. I understand that my dispensing records may be subject to audit by the BC Ministry of Health.

BOX A - In cases where the patient or personal representative* is unable to sign the Patient Declaration:

- | | |
|---|---|
| <input type="checkbox"/> patient has been informed of declaration | Explanation of why patient signature is not possible: |
| <input type="checkbox"/> counselling has been provided to patient | |

Signature of Pharmacist	Print Name of Pharmacist	
	Date Signed (DD / MM / YYYY)	Pharmacist Licence Number