BRITISH COLUMBIA | Ministry of Health

First Nations Health Authority
Health through wellness

BC PHARMACARE PLAN W

OTC RECOMMENDATION

HLTH 4571 2021/08/27

In accordance with the *Pharmaceutical Services Act* section 16(2), this form must be completed each time a Plan W beneficiary is dispensed Schedule 2, Schedule 3, or unscheduled product(s) recommended by a pharmacist and covered by Plan W. Insulins are excluded from this policy. Insulins can be dispensed and the claim entered on PharmaNet without a prescription or this form.

PATIENT AND DRUG INFORMATION

Name of Patient	Birthdate (DD / MM / YYYY)	Personal Health Number (BC Services Card)

Drug Information

This section may include more than one product if required. Number each drug label "Drug 1", "Drug 2", etc. to correspond with the entries in the section for indications and follow-up.

Please attach label(s) with the following information:

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

	Drug indication(s) for patient	Follow-up date(s)/method(s) (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:

☐ patient has been informed of declaration
☐ counselling has been provided to patient

Explanation of why patient signature is not possible:

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

If you have any questions about the collection of this personal information on this form, contact the Health Insurance BC (HIBC) Chief Privacy Officer at PO Box 9035 STN Prov Govt, Victoria BC V8W 9E3 or call 604 683-7151 (Vancouver or 1 800 663-7100 (toll free). This information will be collected used and disclosed in accordance with the s.27(2) *Freedom of Information and Protection of Privacy Act* and the *Pharmaceutical Services Act*.

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