BRITISH COLUMBIA | Ministry of Health

BC SMOKING CESSATION PROGRAM

DECLARATION AND NOTIFICATION

HLTH 5464 2015/12/10

This form must be completed each time a patient is dispensed a smoking cessation prescription drug or nicotine replacement therapy (NRT) product through the BC Smoking Cessation Program.

Name of Patient	Date of Birth (DD/MM/YYYY)	Personal Health Number (BC Services Card/Care Card)

Prescription or NRT Information

Please affix or attach a label with the following information:

- patient name
- prescription number
- practitioner name
- NPN or DIN
- product name
- manufacturer
- product strength
- quantity dispensed
- date dispensed
- directions

PATIENT DECLARATION

I declare that I have active, valid Medical Services Plan (MSP) coverage, that I am a resident of British Columbia, that I use tobacco, and that I am eligible to enroll in Plan S (the Plan for nicotine replacement therapy) if dispensed nicotine replacement therapy. I declare that the medication (CHECK ONE):

☐ eligible nicotine replacement therapy ☐ bupropion (Zyban®) ☐ varenicline (Champix®)

dispensed to me through the BC Smoking Cessation Program ("the program") will be used personally by me to reduce or stop my use of tobacco.

I understand that the BC Ministry of Health may review my PharmaNet and other records to confirm my eligibility for the program and to otherwise administer the program. I understand that the Ministry of Health may contact me for the purposes of program evaluation or planning.

I understand that the pharmacist is collecting this information in accordance with the record keeping requirements in the Pharmaceutical Services Act and that the pharmacy may be required to provide this information to the BC Ministry of Health for the purposes set out above.

print name of patient (or patient's personal representative)*	*signature of patient (or patient's personal representative*)*	*date signed*

**personal representative* means a person having authority under the common law or an enactment to make decisions on behalf of a beneficiary

PHARMACIST DECLARATION

I declare that the patient has received (CHECK ONE):

☐ eligible nicotine replacement therapy ☐ bupropion (Zyban®) ☐ varenicline (Champix®)

as indicated above, through the BC Smoking Cessation Program ("the program") according to program policy. I have updated PharmaNet with the patient's address and telephone number. I understand that my dispensing records may be subject to audit by the BC Ministry of Health and that the Ministry may contact me for the purposes of program evaluation or planning.

print name of pharmacist	*signature of pharmacist*	*date signed*

Completed copies of this form must be retained on file in the pharmacy in accordance with recordkeeping requirements established in the *Pharmaceutical Services Act* and any relevant bylaws of the College of Pharmacists of British Columbia.

PRINT CLEAR FORM