BRITISH COLUMBIA | Ministry of Health

BC SMOKING CESSATION PROGRAM

DECLARATION AND NOTIFICATION

HLTH 5464 2021/10/19

This form must be completed each time a patient is dispensed a 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)

NRT Information

Please affix or attach a label with the following information:

- patient name
- prescription number
- pharmacist name
- NPN
- 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 eligible nicotine replacement therapy 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 support and resources are available to me free of charge through QuitNow.ca that will help me plan my strategy to quit or reduce smoking and increase my chances of success.

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 an eligible nicotine replacement therapy 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.

Personal information on this form is collected by the Ministry of Health under s.22 of the *Pharmaceutical Services Act* for the purpose of determining eligibility for PharmaCare's Smoking Cessation Program (Plan S).
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 *Freedom of Information and Protection of Privacy Act* and the *Pharmaceutical Services Act*.

Save Print Clear Form