

About completing the form

This form is to inform patients that a pharmacist has initiated daily dispensing for their medication(s).

This form is required:

- For payment of a dispensing fee for daily dispensing when the physician or nurse practitioner haven't specified daily dispensing on a prescription,
- The patient meets one of the Eligibility Criteria (Rationale) indicated below, and
- The daily dispense is for a Schedule 1 drug which is NOT a drug identified on the Maintenance Medication List (MML) as defined in Alberta Blue Cross Reference Guide for Alberta Pharmacies.

Methadone and Buprenorphine/Naloxone are exempt from the daily dispensing fee limit; dispensing fees for these medications are automatically approved for payment, and a Daily Dispensing Authorization Form isn't required.

This form must be updated every 3 months.

Please retain the original copy of this form for 2 years for audit and compliance purposes.

A patient's agent means a family member, caregiver, public guardian or another individual whom the pharmacist is reasonably satisfied with the authorization of the patient to engage with the pharmacy team (as defined in Alberta College of Pharmacy Standards of Practice for Pharmacists and Pharmacy Technicians).

This is NOT a standardized form. The format and layout are at the discretion of the pharmacy business; however, all required information elements included in this sample form must be captured and documented to fulfill Alberta Blue Cross audit and claims verification requirements.

Note regarding daily dispense of opioid medications:

A pharmacy shouldn't claim a daily dispensing fee for opioid medication(s) if a daily dispensing fee has already been claimed for Methadone or Buprenorphine/Naloxone for the same patient on the same day.

- Notwithstanding the limitations on daily dispensing fees, **a daily dispensing fee may be payable for an opioid medication prescribed concurrently with opioid agonist therapy** (e.g., methadone or buprenorphine/naloxone) **only where the concurrent opioid is required as part of a specialized, documented treatment protocol authorized by an approved addiction medicine, Narcotic Transition Service or opioid transition program.**
- Concurrent prescribing alone doesn't qualify for this exception.

Daily Dispensing Claim for the Opioid Decision Framework – FOR PHARMACY USE ONLY

1. Is the patient on Methadone or Buprenorphine/Naloxone daily dispense?
2. If yes, is the patient on an opioid, in addition to Methadone or Buprenorphine/Naloxone?
3. If yes, was the opioid medication prescribed as a part of a specialized documented treatment protocol authorized by an approved addiction medicine, Narcotic Transition Service or opioid transition program?
 - If yes, a daily dispensing fee on the opioid can be claimed
 - If no, a daily dispensing fee can't be claimed for the opioid. Concurrent prescribing alone, including a prescription direction for daily dispensing or completion of this form, doesn't qualify for this exception.

Daily Dispensing Authorization Form

PATIENT INFORMATION		
PATIENT LAST NAME	FIRST NAME	INITIAL
DATE OF BIRTH (YYYY/MM/DD)	ALBERTA BLUE CROSS ID AND TAG #	
PHARMACY INFORMATION		
NAME OF PHARMACY	PHONE	FAX

MEDICATION INFORMATION – Use a separate form to list any additional medications, if applicable		
Medication	Rationale for frequent dispensing	Patient/Patient's agent initial
	☐ Risk of theft/loss ☐ Risk of overuse/abuse	
	☐ Risk of theft/loss ☐ Risk of overuse/abuse	
	☐ Risk of theft/loss ☐ Risk of overuse/abuse	
	☐ Risk of theft/loss ☐ Risk of overuse/abuse	

PATIENT/Patient's agent acknowledgement – MUST BE SIGNED	
☐ I understand that the medication(s) identified on this form will be dispensed daily. ☐ I understand that dispensing my medication daily may result in additional dispensing fees, subject to applicable plan rules. ☐ I understand I can refuse the daily dispensing of my medication(s) at any time, unless daily dispensing is specifically indicated on my prescription by my physician or nurse practitioner. ☐ I understand that I can contact Alberta Blue Cross at 1-866-441-8477 if I have concerns regarding my frequency of dispense billing. ☐ I acknowledge that information related to this form may be collected, used, disclosed, or reviewed by Alberta Blue Cross in accordance with applicable legislation and program requirements, including for audit and verification purposes.	
☐ I am the patient. ☐ I am the patient's agent. Relationship to patient, if applicable: _____	
Signature of patient or patient's agent: _____	
The date signed (YYYY/MM/DD): _____ represents the effective date of this consent form.	
Only the patient or their authorized agent may sign this acknowledgement.	
The patient or the patient's agent will receive a copy of this completed consent form for their records.	
Patients or their agents may provide consent by email, and the email confirmation can be retained as documentation of consent.	
PHARMACIST'S SIGNATURE	DATE (YYYY/MM/DD)
WITHDRAWAL OF CONSENT - may be provided by signed written request, email or verbal communication documented by the pharmacist in the patient record.	

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

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