

MAINTENANCE MEDICATIONS FREQUENT DISPENSING AUTHORIZATION FORM

Please complete all required sections to allow your request to be processed.

- This form is to inform patients that a pharmacist has initiated frequent dispensing for their chronic and long-term medication.
- This form is required for less than 84 days dispensing of maintenance medications (as defined in Alberta Blue Cross Reference Guide for Alberta Pharmacies).
- This form must be updated every 12 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 has 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).
- Pharmacists are required to seek and document consent from the patient/patient's agent through appropriate means, consistent with the Alberta College of Pharmacy standards of practice.
- 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 ABC audit and claims verification requirements.

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

MEDICATION INFORMATION – Use a separate form to list any additional medications, if applicable			
Frequency of dispense	Medication and strength	Rationale for frequent dispensing	Patient/Patient's agent initial
28-83 days		☐ Physician/Nurse Practitioner direction ☐ Risk of theft/loss ☐ Residents receiving facility-based care Living (EXCLUDING Continuing Care Type B, Type C, Palliative, and Supportive Living Accommodation) ☐ Medication safety/complex and unstable medication profile ☐ Patient request (including patient requested compliance package)	
2-27 days		☐ Physician/Nurse Practitioner direction ☐ Risk of theft/loss ☐ Residents receiving facility-based care Living (EXCLUDING Continuing Care Type B, Type C, Palliative and Supportive Living Accommodation)	
☐ The above rationale applies to all maintenance medications listed in the patient's profile.			

PATIENT/Patient's Agent acknowledgement – MUST BE SIGNED

- ☐ I understand that the medication(s) identified on this form will be dispensed according to the frequency indicated.
- ☐ I understand that maintenance medications are medicines used regularly to manage long-term health conditions.
- ☐ I understand that, once my condition is stable, I can ask my pharmacist whether an 84 to 100 days supply of my maintenance medication is appropriate for me.
- ☐ I understand that dispensing my medication more frequently may result in additional dispensing fees, subject to the applicable plan rules.
- ☐ I understand I can refuse the more frequent dispensing of my medication(s) at ANY TIME and can withdraw consent at ANYTIME.
- ☐ I understand that I can contact Alberta Blue Cross at 1-866-441-8477 if I have concerns regarding my pharmacist's 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.

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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