FREQUENT DISPENSING AUTHORIZATION FORM

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Manitoba Health, Seniors and Active Living

A Frequent Dispensing Authorization Form is required when the pharmacy wants to request reimbursement for more than two (2) professional fees per 30-day period (or 28-day cycle) for a drug listed on the Frequency of Dispensing List. This Form is not required when 1) the need for an additional dispensing is considered a "one-off" (such as for lost medications); 2) the client is receiving benefits under the Palliative Drug Access Program; 3) the drug is not listed on the Frequency of Dispensing List (such as mental health drugs); or 4) when the client is a resident of an Assisted Living and/or Group Home and the pharmacy has a formal contract to provide services to the facility. Please refer to the Claims Submission Procedure – Dispensing Frequency for definitions.

PATIENT INFORMATION

Patient's Last Name:	Patient's First Name:	Personal Health Identification Number (PHIN):

Frequency of Dispensing: ❑ Weekly ❑ Other (specify):

PHARMACY INFORMATION

Name of Pharmacy:	Provider Number:	Fax Number (including area code):

CLINICAL OR MEDICAL RATIONALE FOR FREQUENT DISPENSING

To qualify for coverage of additional professional fees for more frequent dispensing of a drug(s), a patient must be unable to manage their drug therapy independently. The patient must exhibit one the following:

☐ Patient has a current or prior prescription for a drug product used to manage dementia (such as a cholinesterase inhibitor) or other similar condition.
☐ Patient is at risk of self-harm.

FREQUENCY OF DISPENSING LIST CATEGORY (CHECK ALL THAT APPLY)

The patient is taking one or more drug(s) that are listed on the Frequency of Dispensing List (please select all that apply):

☐ ACE Inhibitors
☐ Angiotensin II Receptor Blockers
☐ Beta Blockers
☐ Calcium Channel Blockers
☐ Other Drugs Used for Hypertension (excluding Clonidine)
☐ Other Cardiac Drugs (excluding anticoagulants)
☐ Statin Drugs Used to Lower Cholesterol
☐ Other Drugs Used to Lower Cholesterol
☐ Oral Anti-diabetic Agents
☐ Diuretics
☐ Drugs Used for GI Conditions
☐ Drugs Used to Prevent Gout
☐ Oral Iron Replacement Therapy
☐ Drugs Used for Osteoporosis
☐ Drugs Used for Prostate Conditions
☐ Thyroid Preparations
☐ Drugs Used for HIV, Hep C

DOCUMENTATION PROVIDED (CHECK ALL THAT APPLY)

☐ A print-out of the client's current Drug Programs Information Network (DPIN) medication history.
☐ Clinical note or copy of a prescription that delineates a current risk of self-harm and that ALL medications should be dispensed more frequently than twice per 30-day period (or 28-day cycle).
☐ Clinical note from the pharmacist describing prior use of a drug product used to manage dementia (such as a cholinesterase inhibitor) that is not evident in the current DPIN record or a description of another similar condition. The pharmacist should clearly outline the clinical or medical need and describe why the patient is unable to manage their drug therapy independently and how more frequent dispensing will assist the patient.

CLINICAL NOTES (attach additional pages if needed)

PHARMACIST DECLARATION

I declare that I have assessed the clinical and therapeutic needs of this patient and declare that more frequent dispensing is required as the patient has complex medical or clinical need which justifies more frequent dispensing (as defined in the Claims Submission Procedure – Dispensing Frequency).

_____ _____ _____

name of pharmacist *pharmacist's initials & license number* *date signed (dd / mm / yyyy)*

Once the form has been completed, fax it to Manitoba Health at 204-946-5070. Responses ("approved" or "rejected") will be faxed directly to the pharmacy, usually within two (2) business days. Completed copies of this form must be retained on file in the pharmacy in accordance with the record keeping requirements of existing Regulations and the Pharmacy Agreement.

FOR INTERNAL MANITOBA HEALTH USE ONLY:

Approved by: _____ Date: _____