PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

MPP DISPENSING FEE FREQUENCY EXCEPTION REQUEST FORM

Fax: 604 419-2689 | www.pac.bluecross.ca/providerresource/

How to complete this form:

PLAN MEMBER or LEGAL REPRESENTATIVE — Please complete RED portions of this form.
Don't forget to sign Part 5 — Member Consent and Declaration OR Part 6 — Legal Representative Consent before submitting. (Only 1 signature is required)
PHARMACIST and PRESCRIBER — Please complete BLACK portions of this form. Both Part 2 and Part 3 must be completed prior to submission.

Pacific Blue Cross may provide coverage of additional dispensing fees beyond what is allowable by the contract for the medical reasons indicated on this form. Completion of this form does NOT imply approval for payment of additional dispensing fees. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

A dispensing fee will be charged each time a medication is dispensed and dispensing medications at an increased frequency will be provided at an added cost to the plan sponsor. Additional dispensing fees may also result in a plan member reaching or exceeding applicable benefit plan maximums.

The plan member is responsible for any fees charged by pharmacist or prescriber for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

PART 1 — PLAN MEMBER INFORMATION

Plan member name		Patient's name	
Patient birthdate (mm-dd-yyyy)	Policy number	ID number	Daytime phone number (10 digits)
Street address	City	Province	Postal code

PART 2 — PHARMACIST TO COMPLETE

Frequency of dispensing requested

☐ Daily ☐ Every 28 days ☐ Other (specify): _____

Name of pharmacy	Phone number	Fax number	PBC provider ID
Name of pharmacist		College ID	

I certify the medical information provided is accurate and current.

Pharmacist's signature X	Date (mm-dd-yyyy)

PART 3 — PRESCRIBER TO COMPLETE

Prescriber's name		College ID	
Street address	City	Province	Postal code

I certify the medical information provided is accurate and current.

Prescriber's signature X	Date (mm-dd-yyyy)

PART 4 — RATIONALE FOR FREQUENT DISPENSING (PHARMACIST OR PRESCRIBER TO COMPLETE)

Please list medications that require daily or monthly dispensing along with documentation of the medical reasons to support your rationale. Additional reports can be included if required.

PART 4 — RATIONALE FOR FREQUENT DISPENSING — CONTINUED (PHARMACIST OR PRESCRIBER TO COMPLETE)

Please list medications that require daily or monthly dispensing along with documentation to support your rationale. Additional reports can be included if required.

PART 5 — MEMBER CONSENT AND DECLARATION (PLEASE SIGN EITHER PART 5 OR PART 6, NOT BOTH)

IMPORTANT: This section must be signed by a Pacific Blue Cross Member where the Member has the capacity to make his/her own decisions. If the member does not have capacity please leave Part 5 blank and have legal representative sign Part 6.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims. I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered. If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s). I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my pharmacist or prescriber to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature **X**	Date (mm-dd-yyyy)

PART 6 — LEGAL REPRESENTATIVE CONSENT (PLEASE SIGN EITHER PART 5 OR PART 6, NOT BOTH)

IMPORTANT: This section may only be signed by a legal representative of the Member. It is not acceptable for a caregiver of the Member who is not the Member's legal representative to sign the form on the Member's behalf.

I am a person legally authorized to provide consent on behalf of the Member named in this form.

I agree to provide to Pacific Blue Cross, at Pacific Blue Cross's request, the relevant legal documentation which proves my legal authorization to provide consent on behalf of the Member named in this form.

I represent that the Member does not have the capacity to consent to the terms and conditions as set out in this form.

By signing Part 6 of this form, I consent to the terms and conditions in this form on the Member's behalf.

Name of legal representative	Nature of legal representative to member
Legal representative's signature **X**	Date (mm-dd-yyyy)