Assisted Living Alberta

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown		

Calgary
Type A Continuing Care Home Formulary
Pharmacy and Therapeutics Committee

COMPOUND MEDICATION FUNDING REQUEST

Form submission is required within the 3 weeks grace period following admission/readmission to a Type A Continuing Care Home (CCH). For new starts at the CCH, form submission is required before initial drug provision.

Processing Instructions: Please complete the form in its entirety, and submit via secure encrypted email emails to the ISFL Type A CCH Pharmacist at:
cc.drugmanagement@albertahealthservices.ca **OR** the pharmacist or physician can fax it to **403-943-0232**

☐ ***NEW request*** ☐ ***TRIAL renewal*** ☐ ***OTHER renewal***

Resident Code:[i]	Date of Birth:	Type A Continuing Care Home:
Drug name/Compound Name (name, formulation, route):		Dose/Regimen:
Physician:	Expected Duration of Therapy:	Daily Drug Cost: OR Total Price of Compound:
Is this a high cost non-formulary request[ii]? ☐ Yes ☐ No Does the Resident have alternate funding that covers the medication? ☐ Yes ☐ No If yes, please specify:		
Section A - Assessment, Monitoring and Outcomes		
1. ☐ New Request		
Indication for Use/Reason for Prescribing (include references and citations used if applicable):		
Relevant Medical History:		
Trials of Formulary (or Non-Formulary Alternatives and Outcomes of Trials:		
Expected Outcome of Therapy/Measures of Success, and Monitoring Parameters:		
Additional Details (as applicable):		
2. ☐ Trial renewal – Initial trial duration: Trial effect/Outcome/Benefit:		Previous Approval Code:
3. ☐ OTHER renewal Update on Resident Status/Monitoring Parameters/Other Detail:		Previous Approval Code:
Section B - Compound Information		
Compound Composition, ingredient details and cost *may attach as separate sheet*		
Ingredient Name (including base)		Ingredient Strength
Total Quantity (optimized based on use & stability):		
Estimated Days' Supply:		Shelf-Life/Stability Dating:
Are there any commercially available alternatives (include consideration of different drug, dose, formulation with expected similar therapeutic effect)? ☐ Yes ☐ No Rationale for compound funding request. Check all that apply[iii].		

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☐	Change in dosage form or strength of a Formulary drug
☐	To replace a Formulary drug unavailable due to a supply issue
☐	Contraindication or intolerance to commercially available alternative
☐	Lack of efficacy of Formulary or commercially available alternative
☐	Other[iii]

THIS SECTION FOR CLINICAL PHARMACIST/PHARMACY PROVIDER USE ONLY
Must be completed prior to submission

Pharmacist's Name:	Phone:
Request Date:	Initial Date of Drug Provision[iv]:

THIS SECTION IS FOR ALBERTA HEALTH SERVICES USE ONLY

Outcome:		
Approval Code:	Approval type:	Date:

[i] First four letters of surname followed by first two letters of given name
[ii] A high cost non-formulary drug is any drug not listed or used in accordance with Formulary criteria that costs more than $250 per month or $230 per dispense
[iii] Compounds ineligible for coverage

- Compounds created for cosmetic purposes
- Compounds that duplicate the effect of an existing pharmaceutical product
- Compounds with unproven effects. Example: topical compounded pain preparation containing ingredients where available scientific evidence demonstrating clinical efficacy and safety is limited

[iv] The date the pharmacy provider started providing the drug