



Calgary
Type A Continuing Care Home Formulary
Pharmacy and Therapeutics Committee

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

FPP-3a NON-FORMULARY DRUG REQUEST

For new starts at the Type A Continuing Care Home (CCH), submission is required prior to initial drug provision. For existing therapy, submission must be completed soon as possible following admission or readmission, and no later than 3 weeks (the allotted grace period) after admission/readmission to a Type A CCH.

Processing Instructions: Please complete the form in its entirety. The pharmacy provider can email it through secure encryption 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 Product:
Is this a high cost non-formulary request ⁱⁱ ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the Resident have alternate funding that covers the medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please specify:		
Section A - Assessment, Monitoring and Outcomes		
1. <input type="checkbox"/> New Request		
Indication for Use/Reason for Prescribing (include references and citations used for off-label applications):		
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. <input type="checkbox"/> Trial renewal – Initial trial duration:		Previous Approval Code:
Trial effect/Outcome/Benefit:		
3. <input type="checkbox"/> OTHER renewal		Previous Approval Code:
Update on Resident Status/Monitoring Parameters/Other Detail:		



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THIS SECTION FOR CLINICAL PHARMACIST/PHARMACY PROVIDER USE ONLY		
<i>Must be completed prior to submission</i>		
Pharmacist's Name:	Phone:	
Request Date:	Initial Date of Drug Provision ⁱⁱⁱ :	
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 The date the pharmacy provider started providing the drug

