Form submission is required once prior to starting medication if initiated in LTC or within six weeks following admission. Funding may be declined or terminated upon notification by LTC Drug Management when criteria are not met, maintained, or determined to not meet current practice recommendations.

**Processing Instructions:** Please fully complete all relevant sections of the form.

Pharmacy provider email to ISFL Long Term Care Pharmacist at:

cc.drugmanagement@albertahealthservices.ca **OR** pharmacist/physician fax to **403-943-0232**

|  |  |  |
| --- | --- | --- |
| [ ]  New Start [ ]  New Admission [ ]  Renewal | [ ]  Confirmation email (check this box if you would like a reply email to confirm SA funding) | Date of Drug Provision by Pharmacy      *or* [ ]  Pending  |
| Resident Code       | Date of Birth      | Date of Admission      |
| Drug | Prescribing Information *(initial start date, dose, specialist or clinic involvement, etc.)*        |
| Physician      | Pharmacist      | Tracking Code *(generated by Pharmacist)*-mmyy-RPh initials |
| **Part 1: Requirements** | **Criteria met**  |
| * Drug selection and dosing have been reviewed with the prescriber and are appropriate for resident’s current status; **and**
* The Interdisciplinary team has reviewed risks and limitations of treatment, including bleeding risk, with the resident/family and incorporated management strategies into the resident’s care plan; **and**
* Anticoagulation will be assessed with regular medication reviews for determination of ongoing benefit versus risk, and alignment with resident’s goals; **and**
* Contraindications and precautions to use (e.g. active bleeding, organ function, drug interactions, frailty, etc.) have been reviewed with the prescriber and have been taken under consideration.
 | **[ ]** **[ ]** **[ ]** **[ ]**  |
| **Part 2: Indications and Formulary Restrictions** | **Criteria met**  |
| NON-VALVULAR ATRIAL FIBRILLATION to prevent stroke and systemic embolism when anticoagulation with formulary first line agent **warfarin** is not possible. * + CHADS2 / CHA2DS2VASC score: required
	+ Warfarin Trial (check *and* complete all that apply) Yes[ ]  or No\*[ ]
		- If Yes, describe previous therapeutic failure or intolerance to warfarin therapy: required

*\*Exception:* Continuation of therapy on admission or transfer to LTC: required: provide/describe context | **[ ]**  |
| PREVENTION OF VENOUS THROMBOEMBOLISM EVENTS [ ]  Hip replacement / repair up to a total of 35 days post surgery* + - Is this as result of a hip fracture? Yes[ ]  or No[ ]

[ ]  Knee replacement / repair up to a total of 14 days post surgery[ ]  Other required Info: provide/describe context | **[ ]**  |
| TREATMENT OF DEEP VEIN THROMBOSIS AND/OR PULMONARY EMBOLISM [ ]  Three months duration[ ]  Up to six months duration  | **[ ]**  |