Alberta

Request for Medication Payment Coverage – Leprosy

Protected B (when completed)

Fax the completed form to Alberta Health CD: 780-415-9609

SECTION 1 – Medication Coverage Request

Patient Identifiers

PHN:	**Name:** Last First	**Date of Birth:** y____ m____ d_____

Ordering Physician

Name: Last First	**Telephone:**

Reason for Request

Medication Order (if more than one medication is requested, submit a separate form for each request.)

Medication name:		
Approximate cost of one unit of medication:		
Approximate total cost of medication for duration of treatment:		
Dispensing Pharmacy Name:	**Telephone:**	**Fax:**

SECTION 2 – For Alberta Health Use Only

Approver:

Name:	**Title:**
Telephone:	

Approved: Yes ☐ **Approved: No ☐**

Signature of Approver:	**Reason not approved:**
Date of Approval: y____ m____ d_____	
Signature of EO/ED:	
Comments:	

NOTES:

- **Approved form will be faxed to Pharmacy by Alberta Health.**
- **Any Health Canada Special Access Program (SAP) drugs should be applied for by the treating physician/clinic**

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Classification: Public