Request for Medication Payment Coverage – Tuberculosis (TB)

Protected B (when completed)

Fax the completed form to Alberta Health Communicable Disease: 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:	☐ **STI/TB Drug Depot** (Fax: 780-735-6803)		
	☐ **Alternate Pharmacy Name:**	**Telephone:**	**Fax:**
Was medication obtained using Special Access Program (SAP) Yes ☐ No ☐ If Yes, attach approval			

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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_____	
If medication obtained via SAP: Signature of EO/ED	
Date of approval: y____ m_____ d_____	
Comments:	

NOTES:

- Approved form for TB treatment will be faxed to STI/TB Depot or the alternate pharmacy by Alberta Health.
- For medication provided by alternate pharmacy:
  - Approved form, medication invoicing and payment information will be faxed to that pharmacy upon approval of coverage