



The Manitoba Pharmaceutical Association

187 ST. MARY'S ROAD • WINNIPEG, MB • R2H 1J2 • PHONE (204) 233-1411 • FAX (204) 237-3468

E-Mail info@mpha.mb.ca

FACSIMILE TRANSMISSION OF PRESCRIPTIONS

*THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
THE MANITOBA PHARMACEUTICAL ASSOCIATION
THE DENTAL ASSOCIATION OF MANITOBA
AND
THE MANITOBA VETERINARY MEDICAL ASSOCIATION
(JOINT STATEMENT)*

PREAMBLE:

Transmission of a prescription or refill authorization, from a prescriber to a pharmacy by facsimile is acceptable when the prescription is in compliance with this joint statement.

This Joint Statement is effective as of May 15, 1999. Prescriptions from facsimile transmission must be entered into the Drug Programs Information Network (DPIN) or they cannot be filled (except for veterinary prescriptions) .

PRINCIPLES:

- (1) All medications may be prescribed by facsimile transmission excluding those medications requiring a triplicate prescription and sales reportable narcotics for personal care homes.
- (2) The prescription must be sent to the one pharmacy of the patient's choice.
- (3) The prescription must be sent from a machine authorized by the prescriber.
- (4) The facsimile equipment at the pharmacy must be under the control of the pharmacist so that the transmission is received and only handled by staff in the pharmacy in a manner which protects the patient's privacy and the confidential information on the transmission.
- (5) The prescription must include the:
 - (a) Date
 - (b) Surname, initials (or given names) and address of the patient
 - (c) Name of the drug or ingredients(s) and strength where applicable
 - (d) Quantity of the drug which may be dispensed
 - (e) Dosage instructions for use by the patient which shall include a specific frequency or interval between refills, when so required
 - (f) Refill authorization where applicable, which shall include the number of refills (and interval between refills, when so required)
 - (g) Prescriber's name, address, fax number and telephone number
 - (h) Prescriber's signature
 - (i) Time and date of transmission
 - (j) Name of the pharmacy intended to receive the transmission

- (k) Signed certification that:
 - i. the prescription represents the original of the prescription drug order,
 - ii. the addressee is the only intended recipient and there are no others, and
 - iii. the original prescription will be invalidated, securely filed and not transmitted elsewhere at another time.

* Required prescription template attached

- (6) The pharmacist is responsible for verifying the origin of the transmission, the authenticity of the prescription and, if not known to the pharmacist, the signature of the prescriber.
- (7) The prescription must be retained on permanent quality paper.
- (8) Facsimile transmissions may be accepted from a practitioner registered to practice in a province of Canada.
- (9) After transmission, the prescriber or their agent must ensure that the original written prescription has been invalidated, securely filed, retained for a period of at least two years, be available for inspection, and not transmitted elsewhere at another time.
- (10) Prescriptions received by facsimile transmission must be appropriately filed at the pharmacy for a period of at least two years and be accessible for validation. It must be handled as the new prescription document hardcopy and filed in sequence by date and number. The entire fax form received should be filed intact as a complete document.
- (11) Computer generated prescriptions must comply with College Statement 1-S53 – Medical Computer Systems: Security and Self-Audit.

First Print	MPPP/04-98
Revision	MPPP/10-98
Revision	MPPP/03-99
Revision	MPhA/01-00

FACSIMILE TRANSMISSION OF PRESCRIPTIONS TEMPLATE

Prescriber Name _____

Registration # _____

Clinic Name _____

Prescriber Address _____

Prescriber Telephone # _____

Prescriber Facsimile Transmission # _____

Patient Given and Surname _____

Patient PHIN _____

Patient DOB _____

Patient Address _____

Rx#1

Refill _____ times every _____ days.

Rx#2

Refill _____ times every _____ days.

Prescriber Name _____

(Please Print)

Prescriber Signature _____

Prescriber Address _____

Date _____

Confidential Facsimile to:

Pharmacy Name _____

Pharmacy Fax # _____

Date: _____ Time: _____

Prescriber Certification

- This prescription represents the original of the prescription drug order.
- The pharmacy addressee noted above is the only intended recipient and there are no others.

- The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.
- Quantity must be stated in words and numerals.

THIS TELECOPY IS **CONFIDENTIAL** AND IS INTENDED TO BE RECEIVED BY THE ADDRESSEE ONLY. IF THE READER IS NOT THE INTENDED RECIPIENT THEREOF, YOU ARE ADVISED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS FACSIMILE IS **STRICTLY PROHIBITED**.