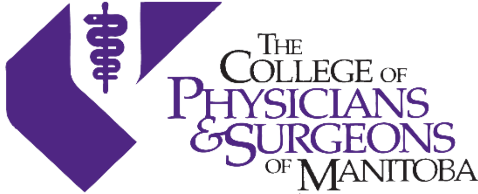

PRACTICE DIRECTION

Facsimile Transmission of Prescriptions

Initial Approval: November 22, 2018 | **Effective Date: January 1, 2019**

Reviewed with NO Changes | **Reviewed with Changes**

Practice Directions set out requirements related to specific aspects of the practice of medicine. Practice Directions are used to enhance, explain, or guide members with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by the College. All members must comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act.*

This Practice Direction is made under the authority of s. 85 of the RHPA and represents requirements of CPSM members in so far as appropriate.

This joint practice statement is the result of **Interprofessional Collaboration** between:

- College of Pharmacists of Manitoba,
- College of Physicians and Surgeons of Manitoba,
- College of Registered Nurses of Manitoba,
- The Manitoba Dental Association, and
- The Manitoba Veterinary Medical Association.

1. PREAMBLE:

1.1. The transmission of a prescription or refill authorization from a prescribing practitioner (which now includes Registered Nurses Extended Practice (RN(EP)) as permitted under the extended practice regulation to *The Registered Nurses Act*), or from a Clinical Assistant (through the delegated function of a medical practitioner) to a pharmacy by facsimile is acceptable when the prescription is in compliance with this joint statement. RNEPs and Clinical Assistants cannot prescribe narcotics, controlled drugs or benzodiazepines.

1.2. All prescriptions from facsimile transmission must be entered into the Drug Program Information Network (DPIN) or they cannot be filled (except for veterinary prescriptions).

2. PRINCIPLES:

2.1. All medications may be prescribed by facsimile transmission excluding those medications requiring a Manitoba Prescribing Practices Program (M3P) prescription (formerly known as a “triplicate” prescription) and sales reportable narcotics for

personal care homes may be transmitted by facsimile when in compliance with this joint statement (RN[EP]s). Clinical Assistants cannot prescribe narcotics, controlled drugs and benzodiazepines.

2.2. The prescription must be sent to the one pharmacy of the patient's choice.

2.3. The prescription must be sent from a machine authorized by the practitioner.

2.4. 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 dispensary in a manner which protects the patient's privacy and the confidential information on the transmission.

2.5. The prescription must include the:
- 2.5.1. Date
- 2.5.2. Surname, initials (or given names) and address of the patient
- 2.5.3. Name of the drug or ingredient(s) and strength where applicable
- 2.5.4. Quantity of the drug which may be dispensed
- 2.5.5. Dosage instructions (and treatment goal and/or diagnosis and/or clinical indications when prescribed by a RNEP or a Clinical Assistant) for use by the patient which shall include a specific frequency or interval between refills, when so required
- 2.5.6. Refill authorization where applicable, which shall include the number of refills (and interval between refills, when so required)
- 2.5.7. Prescribing practitioner's name, address, fax number and telephone number (prescriptions from Clinical Assistants must include this information for the supervising medical practitioner)
- 2.5.8. Prescribing practitioner's signature
- 2.5.9. Time and date of transmission
- 2.5.10. Name of the pharmacy intended to receive the transmission
- 2.5.11. Signed certification that:
  - 2.5.11.a. the prescription represents the original of the prescription drug order,
  - 2.5.11.b. the addressee is the only intended recipient and there are no others, and
  - 2.5.11.c. the original prescription will be invalidated, securely filed and not transmitted elsewhere at another time.

*Required prescription information and suggested template attached.

2.6. 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 prescribing practitioner.

2.7. The prescription must be retained on permanent quality paper.

2.8. Facsimile transmissions may be accepted from a practitioner registered to practice in any province of Canada and in compliance with the Food and Drug Act and the Controlled Drugs and Substances Act and its regulations (RN[EP]), or similar designation, and Clinical Assistant prescriptions from out of province cannot be accepted).

2.9. After transmission, the prescribing practitioner 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.

2.10. 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.

2.11. Computer generated prescriptions must comply with CPSM Practice Direction – Electronic Transmission of Prescriptions.

2.12. Pharmacists may transfer prescription copies by facsimile between pharmacies, where not prohibited by federal legislation.

APPENDIX I

Prescriber Name ___________________________

Registration # _____________________________

Clinic Name ______________________________

Prescriber Address _________________________

____

Prescriber Telephone # _____________________

Prescriber Facsimile Transmission #

____

Confidential Facsimile to:

Pharmacy Name _____________________

Pharmacy Fax #____________________

Date__________________ Time________

Patient Given and Surname

____

Patient PHIN __________________________

Patient DOB___________________________

Patient Address_________________________

____

Rx #1

Partfill ________times every ________ days.

Rx #2

Partfill ________times every ________days.

Prescriber Name________________________
(please print)

Prescriber Signature____________________

Prescriber Address_____________________

____

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

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Use of this form for purposes or by persons, not authorized under the Controlled Drugs and Substances Act and its Regulations is a criminal offence.