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EXPRESS SCRIPTS®

Frequent Dispensing Form

Patient Information

Name:	Cardholder ID:	Date of Birth:

Pharmacist Assessment

In order to qualify for more frequent dispensing of drug(s), a patient must be unable to manage their drug therapy without additional support. It is my professional opinion that the patient above qualifies as a result of:

Physical impairment Clinical description:	Cognitive impairment Clinical description:	Sensory impairment Clinical description:	Complex medication regimen Details:

The dispensing regimen will be:

☐ every 7 days ☐ every 14 days ☐ every 28 days ☐ Other:

The rationale/reason(s) for my assessment of the clinical or safety risks to the patient if larger quantities were dispensed, is/are:

Pharmacist's name:	License #:
Signature:	Date:

Pharmacy Information

Pharmacy name:	Address:
Telephone:	Fax:

Patient Consent

I consent and authorize to have my medication(s) dispensed in reduced quantities from what was originally prescribed, as per the assessment, rationale and dispensing regimen outlined above.

Date:	Agent's Name/Relationship (if applicable):
Patient's signature:	Agent's signature (if applicable):

Prescriber Authorization (if applicable)

The above noted assessment is an accurate reflection of the patient's abilities contributing to the need of more frequent medication dispensing.

Prescriber's name:	Date (DD/MM/YYYY):

Prescriber's signature:

- ***Please complete all sections of the form***
- **It is valid for a period of 365 days**
- **Should there be any discrepancies with your submitted claim(s) and the above documentation, your account will be adjusted accordingly**