Pharmacist Authorized Exempted Codeine Product (ECP)

Initial Request

Patient Information	Name: _____ DOB: _____ MCP #: _____ Allergies: _____ Medications: _____ Medical Conditions: _____ Primary Prescriber: _____
Rationale	Indication: _____ Other meds tried for indication: _____ History of ECP, opioid or similar? ☐ Yes _____ Pharmacy Network reviewed? ☐ Yes
Authorization	Date: _____ Product: _____ Sig: _____ Quantity: _____ Max daily dose/duration: _____ RPh: _____ Reg #: _____
Counselling	☐ Discussed the effects/risks of codeine, acetaminophen and/or ASA overuse ☐ If adequate symptom relief does not occur or prolonged use is required see physician for assessment. ☐ Only take as needed for the minimum duration possible Other comments: _____ RPh: _____ Date/Time: _____

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