

Can handwrite or type your information in this box. Contact CPSM for templates to prepopulate to save time.

EXAMPLE: SUBOXONE ON ORIGINAL M3P FORM

For Facsimile Transmission of M3P Prescriptions During COVID-19

Strong Recommendation to write total daily dose (vs 2 mg tablet sizes x 2 for this induction dose) to give pharmacist flexibility to use the strengths available to make up dose.

Prescriber Name
Dr. Good Example

Registration # **12-345**

Clinic Name
GOOD HEALTH CLINIC

Prescriber Address
**123 Good Street
Winnipeg MB, R3M 0V9**

Prescriber Telephone #
**204-232-1991 (private cell)
204-788-8686 (Good Health Clinic)**

Prescriber Facsimile # **204-788-8685**

Prescriber must complete Total Quantity in mg, alphabetically and numerically, for accuracy, even if start and end date noted. And even for a dose x 1, where the dose and the total quantity are the same.

Prevents treatment delay if clarification needed.

*Attach completed M3P form and indicate dose in numbers and words in box below.

MANITOBA PRESCRIBING PRACTICES PROGRAM FORM (M3P)
(VOID AFTER 3 DAYS)

PATIENT INFORMATION

Surname **SMITH** First Name **SUSAN**
Address **#45-6 Goodman St. Ste. 1010** City/Town **WOLSELEY**
PHN **123456789** DOB **150989**
D M Y

PRESCRIPTION INFORMATION - (1 Medication per form - No Refills Permitted)

Name of Drug and Strength
SUBOXONE 4mg

Total Quantity
Numerical **4** Written **Four milligrams**
To be dispensed in lots of (qty) **1**
At interval of (# days) **1**

Therapeutic Indication **Opioid Use Disorder**
Rx Direction **Suboxone 4 (Four) mg SL x 1 on October 28, 2021 @ 17h30**

Practitioner Signature X **[Signature]** D M Y **28/10/21**

Witnessed dose **[Signature]** DR. G. EXAMPLE 12-345

PHARMACY USE ONLY

Client Identification Validation YES NO Practitioner Identification Validation YES NO
Patient Profile Review Refusal to Fill
Pharmacist Intervention/Comments: _____
Pharmacist Signature _____
Pharmacist Lic. # _____ Rx # _____

PHARMACY

Requirement to strike through, as intervals indicated in witness and/or carry instructions, which must be written below.

Total daily dose, written numerically and alphabetically, for accuracy. Start and End calendar dates necessary for OAT. If patient missed dose on day 10 of 28-day Rx, they cannot take it day 29 (Rx ends on day 28). Prescriber to be informed of any missed doses. Even for dose x 1 the date must be written. For an induction Rx can also indicate the time for the dose.

Can use this space to write witness or carry dose instructions for clarity.

Confidential Facsimile to:

Pharmacy Name
Example Pharmacy

Pharmacy Fax # **204 588 8687**

Pharmacy PH # **204 588 8689**

Date **October 28, 2021**

Time **1430**

If a M3P prescription is being faxed, the daily dosage **must** be clearly indicated below (in addition to being noted on the M3P form itself): **Suboxone 4 (Four) mg SL x 1**

Example of induction prescription for patient on the first day.

Practitioner 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 will not be transmitted elsewhere at another time.
- Quantity is 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.

Daily dose written numerically and alphabetically, in this second area to ensure accuracy, in case fax artifacts cover the primary daily dose notation.