northern health
the northern way of caring

Symptom Management Kit

Pharmacy Invoice

Invoicing date/period: _____ **Pharmacy:** _____

Pharmacy address: _____ Phone: _____

Pharmacist/technician signature: _____

Replacement for expired medications from kit

Description	Unit of measurement (UOM)	Max price/ UOM*	Quantity	Old expiry	Drug cost	
dexamethasone 10 mg/mL, 10 mL	1 mL	1.3856				
glycopyrrolate 0.2 mg/mL, 2 mL	1 mL	4.2962				
haloperidol 5 mg/mL, 1 mL	1 mL	5.2164				
HYDROmorphone 10 mg/mL, 1 mL	1 mL	3.6450				
LORazepam 1 mg sublingual	Tablet	0.1243				
methotrimeprazine 25 mg/mL, 1 mL	1 mL	4.0662				
metoclopramide 5 mg/mL, 2 mL	1 mL	3.6639				
midazolam 5 mg/mL, 2 mL	1 mL	4.4280				
morphine 10 mg/mL, 1 mL	1 mL	2.2172				
				Subtotal of expired medication items	$	**A**

*Max price as per Pharmacare LCA masterspreadsheet (last updated August 2021).

Program management fees

Maintenance fee: **$35** per kit in pharmacy x _____ kits $	**B**

Total amount owing to pharmacy (A + B) $

In order to process payment, please fax this completed invoice with prescription receipts to:
Administrative Assistant NH Palliative Care Program Fax 250-565-5596