

PHARMACISTS SHOULD NOTIFY PRESCRIBER WHEN MAKING CHANGES TO A PRESCRIPTION

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Common situations exist where pharmacists find it necessary to make changes to a prescription prior to dispensing. One common example occurs when an insurance provider pays for a split tablet of the higher dose, such as Zoloft 100mg and not for the whole lower dose 50mg tablet originally prescribed. Another example may occur due to a lack of availability of a specific strength of the medication such as a prescription for Ritalin 10mg which might be dispensed as two 5mg tablets because the higher dose tablet is out of stock. In both cases the patient gets the correct drug in the proper daily dose, but in a way not expected or noted by the prescriber.

In a recent meeting between members of the Board of Pharmacy and representatives of the Oregon Medical Association, it was brought to the Board's attention that some confusion is being created when changes to a prescription are made by a pharmacist and the prescriber is not notified. An understanding was reached regarding the need for improved communication between pharmacists and prescribers.

The confusion arises when the prescriber talks with the patient in terms of the number of pills or tablets, rather than in milligrams. A problem may be created when the prescriber wants to discuss the dose with a patient, or to adjust the dose and instructs the patient to increase or decrease the number of "pills". In the Ritalin example, the doctor might instruct a patient to increase the dose to two tablets when the patient was already taking two. In the Zoloft example, the doctor might instruct the patient to break the tablet and take half when he or she was already taking half. Ineffective communication leads to confusion, and may result in the patient receiving the wrong dose or the wrong information.

The representatives of the OMA and the Board agreed that prescribers should be notified when these types of changes are made by the pharmacist. Most felt that the preferred method would be to send a fax after dispensing that the prescriber could file or note in the patient's chart for reference. Additional telephone calls during the day were not considered to be helpful unless the prescriber needs to be made aware of a proposed change for clarification prior to dispensing.

The importance of clear and careful communication between the pharmacist, the prescriber and the patient cannot be overstated. It is the responsibility of the pharmacist to provide the appropriate prescribed medication, as well as accurate, understandable and useful information to the patient and to the prescriber.