CONTINUATION OF THERAPY

Including Emergency Refills of Insulin

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE:

- Per ORS 689.645, a pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.
- Per ORS 689.696, a pharmacist may prescribe and dispense emergency refills of insulin and associated insulin-related devices and supplies to a person who has evidence of a previous prescription from a licensed health care provider.

- Following all elements outlined in OAR 855-020-0110, a pharmacist licensed and located in Oregon may prescribe any non-controlled medication to a person who has evidence of a previous prescription from a licensed health care provider in order to:
  - Replace a damaged prescription therapy within the original duration of therapy; or
  - Extend a patient's current prescription therapy (same drug, dose and directions) to avoid interruption of treatment.

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

- Utilize the standardized Continuation of Therapy Patient Intake Form (pg. X)
- Utilize the standardized Continuation of Therapy Assessment and Treatment Care Pathway (pg. X-X)
- Utilize the standardized Continuation of Therapy Prescription Template *optional* (pg. X)
- Utilize the standardized Patient Informational Handout *optional* (pg. X)
- Utilize the standardized Continuation of Therapy Provider Fax *optional* (pg. X)

PRESCRIBING PARAMETERS

- **For Non-Insulin Medication, Medication Related Devices and Supplies:**
  - Quantity sufficient for the circumstances
  - Maximum quantity:
    - Damaged: May not exceed original duration of therapy
    - Extend: May not exceed a 60-day supply
  - Maximum frequency:
    - Damaged: No more than one replacement in a rolling 12-month period per medication
    - Extend: No more than two extensions in a rolling 12-month period per medication

- **For Insulin, Insulin Related Devices and Supplies (excluding pump devices):**
  - Quantity sufficient for the circumstances
  - Maximum quantity: Lesser of a 30-day supply or the smallest available package size
  - Maximum frequency: No more than three extensions in a calendar year (Jan 1- Dec 31)

PHARMACIST TRAINING/EDUCATION: None required.

Continuation of Therapy: Self-Screening Patient Intake Form

(CONFIDENTIAL-Protected Health Information)

Date _____/_____/_____ Date of Birth _____/_____/_____ Age_____
Legal Name_____ Name _____
Sex Assigned at Birth (circle) M / F Gender Identification (circle) M / F / Other____
Pronouns (circle) She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, Other_____
Street Address _____
Phone ( ) _____ Email Address _____
Healthcare Provider Name _____ Phone ( ) _____ Fax ( ) _____
Do you have health insurance? Yes / No Insurance Provider Name _____
Any allergies to medications? Yes / No If yes, please list _____

Background Information:

1.	Which medication or medication-related devices and supplies do you need an refill of today?_____ _____	
2.	Why are you unable to obtain a refill from your previous prescriber? _____	
3.	Have you previously had the medication or medication-related devices and supplies needed in #1 prescribed to you by a licensed health care provider? - If yes, what is the name and contact information for your licensed health care provider? _____ - If yes, when was the last time your provider prescribed the medication or medication-related device or supply to you? ___/___/_____	□ Yes □ No
4.	Do you have evidence of a previous prescription for the medication or medication-related device or supply needed in #1 from a licensed health care provider? - If yes, what evidence do you have? □ Prescription Vial □ Medical Record □ Other _____	□ Yes □ No
5.	Have you previously had medication or medication-related device or supplies prescribed to you by a Pharmacist? - If yes, what is the name and contact information for your pharmacist/pharmacy that prescribed to you? _____ - If yes, when was the last time a pharmacist prescribed medication or medication-related device or supply to you? ___/___/_____	□ Yes □ No

Patient Signature_____Date_____
(Parent or Legal Guardian signature needed if patient is under 18 years of age)

To Be Completed by a Pharmacist:

If medication or medication-related device or supply were prescribed/dispensed, please complete the following:

Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: □ Prescription Vial □ Medical Record □ Other	Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: □ Prescription Vial □ Medical Record □ Other
Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: □ Prescription Vial □ Medical Record □ Other	Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: □ Prescription Vial □ Medical Record □ Other

Primary Care Provider (if known) contacted/notified of therapy Date _____/_____/_____

If medication or medication related device or supplies were not prescribed/dispensed/administered, please indicate reason(s) for referral: _____
_____

RPH Signature_____Date_____

Emergency Refills of Insulin or Insulin-Related Devices
Assessment and Treatment Care Pathway
(CONFIDENTIAL-Protected Health Information)

1. Does the patient need a medication or medication-related device/supply today?	
☐ Yes. Go to #2	☐ No. Do not prescribe.
2. If insulin-related supplies are needed, do these supplies include insulin pump devices?	
☐ Yes. Refer patient to other HCP	☐ No. Go to #3
3. Does the patient have evidence of a previous prescription for the needed medication or medication-related device or supply from a licensed health care provider?	
☐ Yes. Go to #4	☐ No. Refer patient to local primary care provider (PCP), emergency department (ED) or urgent care.
4. Has the patient received more than: a. one refill of non-insulin medication, medication-related device or supply from a pharmacist in the past rolling 12-months? b. two emergency refills of insulin or insulin-related supplies from a pharmacist in the past calendar year (1/1-12/31)	
☐ Yes. Do not prescribe. Refer patient to local primary care provider (PCP), emergency department (ED) or urgent care.	☐ No. Prescription recommended. Pharmacist must notify the provider.

Please refer to ORS 689.696 for specific laws concerning emergency refills of insulin and associated insulin-related devices and supplies.

RECOMMENDED REGIMEN:

Medication or medication-related device or supply	Notes:
	• Emergency prescribing must be for the same drug or related supply, strength, and dosage as shown by the patient evidence. • Emergency prescribing for non-insulin medications, devices or supplies is limited to a 60-day supply • Emergency prescribing for insulin or insulin-related supplies is limited to the lesser of a 30-day supply or the smallest available package size.

COUNSELING POINTS:

- To help plan, ask your health care provider for a prescription lasting more than 30 days to ensure you always have enough.
- In a case where you know you are going to need a refill while traveling, you may be able to order an additional supply in advance. Some health insurance plans allow for prescription overrides so that you can get a prescription filled early or obtain more than a 30-day supply.
- Keep an up-to-date list of all your prescription medications.

Continuation of Therapy Prescription

Optional-May be used by pharmacy if desired

Patient Name:	Date of birth:
Address:	
City/State/Zip Code:	Phone number:

☐ Verified DOB with valid photo ID

Rx

☐ **Drug:** _____
- Directions: _____
- Quantity: _____ + 0 refills

☐ **Drug:** _____
- Directions: _____
- Quantity: _____ + 0 refills

☐ **Drug:** _____
- Directions: _____
- Quantity: _____ + 0 refills

☐ **Drug:** _____
- Directions: _____
- Quantity: _____ + 0 refills

Written Date: _____

Prescriber Name:_____Prescriber Signature: _____

Pharmacy Address:_____Pharmacy Phone: _____

Optional-May be used by pharmacy if desired

Patient Information
Continuation of Therapy

Pharmacy Name: _____Pharmacist Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

Your pharmacist, _____, authorized a refill of the medication, devices and/or supplies listed below to prevent an interruption in your therapy.

- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills
- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills
- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills
- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills

Follow-up and Next Steps

- Please contact your primary care provider to obtain further authorization to fill this medication.

Provider Notification
Continuation of Therapy

Pharmacy Name:_____ Pharmacist Name: _____
Pharmacy Address:_____
Pharmacy Phone:_____ Pharmacy Fax: _____

Dear Provider_____ (name), (____) _____ -_____ (FAX)

On _____/_____/_____, your patient _____(name) _____/_____/_____ (DOB) was assessed for a refill of the medication, medication-related devices, and supplies listed below at _____ Pharmacy. Your patient was:

☐ **Prescribed medication or medication related devices and supplies**. The prescription(s) issued and dispensed consisted of:

- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills
  - Evidence Provided: ☐ Prescription Vial ☐ Medical Record ☐ Other
- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills
  - Evidence Provided: ☐ Prescription Vial ☐ Medical Record ☐ Other
- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills
  - Evidence Provided: ☐ Prescription Vial ☐ Medical Record ☐ Other
- ☐ **Drug:** _____
  - Directions: _____
  - Quantity: _____ + 0 refills
  - Evidence Provided: ☐ Prescription Vial ☐ Medical Record ☐ Other

☐ **Referred to**: ☐ Primary care provider (PCP) ☐ Emergency department (ED) ☐ Urgent care for the following reasons:

_____
_____
_____
_____
_____

Medication or medication-related devices and supplies were not prescribed to your patient.

In authorizing this refill, the pharmacist used their professional judgment to meet the patient's medical needs.

RPH Signature_____ RPH Name (Print)_____ Date: _____

Please contact us if you have any questions about the care provided to our mutual patient or if you would like to obtain additional information please contact the pharmacy. The prescription(s) was issued pursuant to the Board of Pharmacy protocol authorized under OAR 855-020-0300.