

Patient Project ID: _____
Staff Project ID: _____
Pharmacy Project ID: _____

Form Approved
OMB No: 0920-XXXX
Exp. Date: XX/XX/XXXX

Pharmacy Record Abstraction Form

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Pharmacy Record Abstraction Form

Was Medication Therapy Review conducted in the past 3 months? yes no

Was a *Personal Medication Record* completed? yes no date: ____/____/____

Was a *Medication-related action plan* conducted? yes no date: ____/____/____

Was individualized adherence support provided? yes no date: ____/____/____

Pharmacist's Recommendations (use additional pages for each additional recommendation)							
What kind of Medication Therapy Review was conducted?		<input type="checkbox"/> Targeted Medication Review <input type="checkbox"/> Comprehensive Medication Review <input type="checkbox"/> Medication reconciliation <input type="checkbox"/> Scheduled medication follow-up				date: ____/____/____	
Medication name/strength/dose:		Conflicting Drug or Disease State (if applicable):					
General therapy issue (s) identified	HIV specific therapy issue(s) identified	Suggested Resolution (see Appendices 1 and 2)	Pharmacist Recommendation	Clinic contacted?	Was an action plan developed with clinic?	Describe action plan	Non-HIV health conditions identified
<input type="checkbox"/> discrepancies between medication lists <input type="checkbox"/> drug interaction <input type="checkbox"/> insufficient dose/duration <input type="checkbox"/> excessive dose/duration <input type="checkbox"/> unnecessary therapy <input type="checkbox"/> suboptimal drug therapy <input type="checkbox"/> adherence—over/underuse <input type="checkbox"/> administration	<input type="checkbox"/> needs therapy <input type="checkbox"/> suboptimal drug therapy <input type="checkbox"/> complex drug therapy <input type="checkbox"/> over-the-counter therapy <input type="checkbox"/> not on 3 active HIV drugs <input type="checkbox"/> not on preferred regimen <input type="checkbox"/> on single tablet			<input type="checkbox"/> yes <input type="checkbox"/> no How was clinic contacted? <input type="checkbox"/> phone <input type="checkbox"/> fax <input type="checkbox"/> email <input type="checkbox"/> in person <input type="checkbox"/> other: _____ Date clinic	<input type="checkbox"/> yes <input type="checkbox"/> no How did clinician accept recommendation? <input type="checkbox"/> phone <input type="checkbox"/> fax <input type="checkbox"/> email <input type="checkbox"/> in person <input type="checkbox"/> other: _____		# of non-HIV conditions identified: ____ Non-HIV conditions identified: (see Appendix

<p>technique</p> <ul style="list-style-type: none"> <input type="checkbox"/> adverse drug reaction <input type="checkbox"/> complex drug therapy <input type="checkbox"/> cost efficacy <input type="checkbox"/> other 	<p>regimen and another ARV*</p> <ul style="list-style-type: none"> <input type="checkbox"/> not on appropriate prophylaxis <input type="checkbox"/> HIV viral load levels are detectable <input type="checkbox"/> co-infected with HIV/HBV^ and not on a preferred regimen <input type="checkbox"/> CrCl† ≤60 min/mL or goes ≥25% from baseline <input type="checkbox"/> rise in LFTs‡ <input type="checkbox"/> patient is on tenofovir but no serum Creatinine has been drawn <input type="checkbox"/> ARV therapy is not synchronized to be filled on the same date <input type="checkbox"/> patient has been without ARVs for 3 or more consecutive days OR 9 days total in the 90 day period. 			<p>contacted:</p> <p>____/____/____</p>	<p>_____</p> <p>Date clinician accepted recommendation:</p> <p>____/____/____</p>		<p>3)</p>
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* ARV = antiretroviral ^HBV = hepatitis B virus †CrCl= Creatinine clearance ‡LFTs= liver function tests

Is follow-up with patient required? yes no Follow-date(s): date: ____/____/____

Was a pharmacist recommendation or pharmacist/clinic action plan implemented? yes no

For patients with adherence problems identified during the CMR/TMR(s), were barriers to adherence identified? yes no

If yes, please complete the following:

Identified Adherence to Therapy Barriers (use additional pages for each additional medication)					
Medication name/strength/frequency:					
Barrier(s) identified	Intervention or Recommendation	Clinic contacted?	Clinician accepts recommendation?	If no, was action plan developed with clinic?	Describe action plan
<input type="checkbox"/> poor understanding of when and how often to take meds	<input type="checkbox"/> patient education/monitoring	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> poor understanding of why they need to take meds	<input type="checkbox"/> patient education/monitoring	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> regimen is too complex		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> too many pills	<input type="checkbox"/> change to combination therapy	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> side effects	<input type="checkbox"/> patient education/monitoring <input type="checkbox"/> add medication/regimen <input type="checkbox"/> discontinue medication/regimen <input type="checkbox"/> alter regimen/change drug due to safety <input type="checkbox"/> alter compliance or administration technique <input type="checkbox"/> other	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> forgets to refill	<input type="checkbox"/> auto refill <input type="checkbox"/> text reminder/emails/phone call <input type="checkbox"/> delivery		<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> transportation problems getting to pharmacy to pick up meds		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> no time to pick up meds		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> can't afford		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	
<input type="checkbox"/> other:		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A	

In the past 3 months, please list each prescription picked up by the client

Prescription Refills						
Medication	Dose	Frequency	# dispensed	Prescription start date	Refill due date*	Date refill picked up*
ART						
Other (?)						

*If there is more than 1 refill, for the same medication, in the past 3 months, list each refill due date and refill pick up date separately

Appendix 1: Therapy issues identified and suggested resolutions

For each therapy issue identified select a suggested resolution to record in the table under “suggested resolution”

Therapy issue identified	Suggested resolution
1. Discrepancies found between multiple medication lists	1.1. Consider discontinuing medication and starting_____ 1.2. Confirm which medication patient should be taking 1.3. Confirm which dose of medication patient should be taking 1.4. Confirm which dosing form patient should be taking 1.5. Confirm which route patient should be taking
2. Drug interaction	2.1 Consider discontinuing medication 2.2 Consider discontinuing medication and starting_____ 2.3 Consider changing dose of medication from_____ to_____
3. Insufficient dose/duration (based on age, kidney, liver, lab results, or health condition)	3.1 Consider discontinuing medication and starting_____ 3.2 Consider changing dose of medication from_____ to _____ 3.3 Other
4. Excessive dose/duration (based on age, kidney, liver, lab results, or health condition)	4.1 Consider discontinuing medication and starting_____ 4.2 Consider changing dose of medication from_____ to _____ 4.3 Other
5. Unnecessary therapy	5.1 Medication may be an unnecessary duplication with _____ 5.2 Medication does not correspond with a known health condition 5.3 Other
6. Suboptimal drug therapy	6.1 Medication may not be appropriate based on patient age 6.2 Medication may not be appropriate based on patient health condition 6.3 Other
7. Adherence - Prescription refill history indicates over/underuse	7.1 Prescription refill history indicates patient is OVERUTILIZING medication 7.2 Prescription refill history indicates patient is UNDERUTILIZING medication 7.3 Other
8. Other drug therapy problem	
9. Adherence - Patient self-reports over/underuse	9.1 Consider discontinuing and starting_____ 9.2 Other
10. Administration technique	10.1 Consider changing medication to dosage form/device such as_____ 10.2 Other
11. Adverse drug reactions	11.1 Consider discontinuing medication 11.2 Confirm existence of side effect Other
12. Cost efficacy management	12.1 Consider discontinuing medication and starting_____

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	12.2 Consider changing medication to a generic, such as _____ 12.3 Consider patient for enrollment into medication assistance program 12.4 Other
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Appendix 2: Health conditions identified and suggested resolutions

For each health condition identified select a suggested resolution to record in the table under “suggested resolution”

Health Condition identified	Suggested resolution
1. Needs therapy	1.1. Confirm patient needs additional therapy for health condition and consider starting____ 1.2. Confirm patient needs additional therapy for health condition 1.3. Other
2. Suboptimal drug therapy	2.1. May be a more effective medication option for health condition 2.2. Other
3. Complex drug therapy	3.1. Patient has issues with self-monitoring of health condition 3.2. Patient unable to manage taking current medication regimen for ____ 3.3. Other
4. Over-the-counter therapy	4.1. Patient taking an over-the-counter therapy that may not be indicated for his/her health condition 4.2. Patient is overusing over-the-counter therapy 4.3. Other
5. Patient is not taking at least 3 active drugs to treat HIV infection (boosting agent, such as ritonavir or cobicistat, do not count toward the 3 active drug regimen)	5.1. Consider discontinuing____ 5.2. Consider discontinuing____ and starting____ 5.3. Consider starting____ 5.4. Other
6. Patient is not on a DHHS preferred regimen or alternate regimen	6.1. Consider discontinuing____ 6.2. Consider discontinuing____ and starting____ 6.3. Consider starting____ 6.4. Other
7. Patient is taking a single tablet regimen (e.g. Atripla, Complera, Stribild, Trizivir) and is also taking another antiretroviral	7.1. Consider discontinuing____ 7.2. Consider discontinuing____ and starting____ 7.3. Consider starting____ 7.4. Other
8. Patient CD4 count performed within the last 12 months is below 200 cells/ μ L and patient is NOT taking appropriate prophylaxis	8.1. Consider discontinuing____ 8.2. Consider discontinuing____ and starting____ 8.3. Consider starting____ 8.4. Other
9. Viral load has been conducted in last 6 months, levels are detectable, adherence assessment complete, and a plan has been developed with provider to perform intervention	9.1. Consider discontinuing____ 9.2. Consider discontinuing____ and starting____ 9.3. Consider starting____ 9.4. Other
10. Patient is co-infected with HIV/HBV and is not on a preferred backbone of either tenofovir + emtricitabine or tenofovir + lamivudine	10.1. Consider discontinuing____ 10.2. Consider discontinuing____ and starting____ 10.3. Consider starting____

	10.4. Other
11. If CrCl drops to \leq 60 mL/min, then make an assessment, plan, and contact clinic OR if CrCl drops \geq 25% from baseline, then make an assessment, plan, and contact clinic	11.1. Consider discontinuing_____ 11.2. Consider discontinuing_____ and starting_____ 11.3. Consider starting_____ 11.4. Other
12. Rise in LFTS	12.1. If LFTs (ALT and/or AST) increase 1.25 - 2.5 times the upper limit of normal (grade 1) then make an assessment and plan 12.2. If LFTs (ALT and/or AST) increase 2.6 - 5 times the upper limit of normal (grade 2), then make an assessment and plan and contact clinic directly 12.3. If LFTs (ALT and/or AST) increase >5.1 times the upper limit of normal (grades 3 [5.1-10 x ULN] and 4 [>10 x ULN]) then make an assessment and plan and contact clinic immediately
13. Patient is taking tenofovir and Serum Creatinine has not been evaluated in 6 months	13.1. Contact prescriber to schedule test 13.2. Patient has test scheduled on date_____
14. ARV therapy is not synchronized to be filled on the same date	14.1. Provided short fill 14.2. Provided long fill 14.3. Other
15. Using sold dates, over the past 90 days has the patient been either without ARV's for 3 or more consecutive days OR 9 days total in the 90 day period.	15.1. Consider discontinuing_____ 15.2. Consider discontinuing_____ and starting_____ 15.3. Consider starting_____ 15.4. Other
16. Other.	

Appendix 3: Non-HIV health conditions identified

1. Alzheimer's Disease
2. Arthritis
3. Asthma
4. Atrial Fibrillation
5. Benign Prostatic Hyperplasia (BPH)
6. Cancer
7. Chronic Obstructive Pulmonary Disease (COPD)
8. Depression
9. Diabetes
10. Esophagitis/Gastroesophageal reflux (GERD)
11. Gout Unspecified
12. Heart Failure, Unspecified
13. Hypercholesterolemia
14. Hypertension
15. Myocardial Infarction
16. Osteoporosis
17. Pain
18. Parkinson's Disease
19. Recent Hospital Discharge
20. Other (write in condition)