Form Approved

OMB No: 0920-XXXX

Exp. Date: XX/XX/XXXX

**Pharmacy Record Abstraction Form**

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

**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:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

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| **Pharmacist’s Recommendations** (*use additional pages for each additional recommendation*) | | | | | | | | |
| What kind of Medication Therapy Review was conducted? | | □ Targeted Medication Review  □ Comprehensive Medication Review  □ Medication reconciliation  □ 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 |
| □ discrepancies between medication lists  □ drug interaction  □ insufficient dose/duration  □ excessive dose/duration  □ unnecessary therapy  □ suboptimal drug therapy  □ adherence—over/underuse  □ administration technique  □ adverse drug reaction  □ complex drug therapy  □ cost efficacy  □ other | □ needs therapy  □ suboptimal drug therapy  □ complex drug therapy  □ over-the-counter therapy  □ not on 3 active HIV drugs  □ not on preferred regimen  □ on single tablet regimen and another ARV\*  □ not on appropriate prophylaxis  □ HIV viral load levels are detectable  □ co-infected with HIV/HBV^ and not on a preferred regimen  □ CrCl† ≤60 min/mL or goes ≥25% from baseline  □ rise in LFTs‡  □ patient is on tenofovir but no serum Creatinine has been drawn  □ ARV therapy is not synchronized to be filled on the same date  □ patient has been without ARVs for 3 or more consecutive days OR 9 days total in the 90 day period. |  |  | □ yes □ no  How was clinic contacted?  □ phone  □ fax  □ email  □ in person  □ other:  **Date clinic contacted:**  \_\_/\_\_/\_\_\_ | □ yes □ no  How did clinician accept recommendation?  □ phone  □ fax  □ email  □ in person  □ other:  **Date clinician accepted recommendation:**  \_\_/\_\_/\_\_\_ | |  | # of non-HIV conditions identified: \_\_\_\_  Non-HIV conditions identified:  (see Appendix 3) |

\* 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 |
| □ poor understanding of when and how often to take meds | □ patient education/monitoring | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ poor understanding of why they need to take meds | □ patient education/monitoring | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ regimen is too complex |  | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ too many pills | □ change to combination therapy | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ side effects | □ patient education/monitoring  □ add medication/regimen  □ discontinue medication/regimen  □ alter regimen/change drug due to safety  □ alter compliance or administration technique  □ other | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ forgets to refill | □ auto refill  □ text reminder/emails/phone call  □ delivery |  | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ transportation problems getting to pharmacy to pick up meds |  | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ no time to pick up meds |  | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ can’t afford |  | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ N/A |  |
| □ other: |  | □ yes □ no | □ yes □ no □ N/A | □ yes □ no □ 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** | | | | | | |
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| **Other (?)** | | | | | | |
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\*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. Consider discontinuing medication and starting\_\_\_\_\_\_\_   2. Confirm which medication patient should be taking   3. Confirm which dose of medication patient should be taking   4. Confirm which dosing form patient should be taking   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\_\_\_\_\_  12.2 Consider changing medication to a generic, such as\_\_\_\_\_  12.3 Consider patient for enrollment into medication assistance program  12.4 Other |

**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. Confirm patient needs additional therapy for health condition and consider starting\_\_\_\_   2. Confirm patient needs additional therapy for health condition   3. Other |
| 1. **Suboptimal drug therapy** | * 1. May be a more effective medication option for health condition   2. Other |
| 1. **Complex drug therapy** | * 1. Patient has issues with self-monitoring of health condition   2. Patient unable to manage taking current medication regimen for \_\_\_\_\_   3. Other |
| 1. **Over-the-counter therapy** | * 1. Patient taking an over-the-counter therapy that may not be indicated for his/her health condition   2. Patient is overusing over-the-counter therapy   3. Other |
| 1. **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)** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. Other |
| 1. **Patient is not on a DHHS preferred regimen or alternate regimen** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. Other |
| 1. **Patient is taking a single tablet regimen (e.g. Atripla, Complera, Stribild, Trizivir) and is also taking another antiretroviral** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. Other |
| 1. **Patient CD4 count performed within the last 12 months is below 200 cells/µL and patient is NOT taking appropriate prophylaxis** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. **Other** |
| 1. **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** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. Other |
| 1. **Patient is co-infected with HIV/HBV and is not on a preferred backbone of either tenofovir + emtricitabine or tenofovir + lamivudine** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. Other |
| 1. **If CrCl drops to ≤ 60 mL/min, then make an assessment, plan, and contact clinic OR if CrCl drops ≥ 25% from baseline, then make an assessment, plan, and contact clinic** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. Other |
| 1. **Rise in LFTS** | * 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   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   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 |
| 1. **Patient is taking tenofovir and Serum Creatinine has not been evaluated in 6 months** | * 1. Contact prescriber to schedule test   2. Patient has test scheduled on date\_\_\_\_\_ |
| 1. **ARV therapy is not synchronized to be filled on the same date** | * 1. Provided short fill   2. Provided long fill   3. Other |
| 1. **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.** | * 1. Consider discontinuing\_\_\_\_\_   2. Consider discontinuing\_\_\_\_\_ and starting\_\_\_\_\_   3. Consider starting\_\_\_\_\_   4. Other |
| 1. **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, Unspecifed

 13. Hypercholesterolemia

 14. Hypertension

 15. Myocardial Infarction

 16. Osteoporosis

 17. Pain

 18. Parkinson’s Disease

 19. Recent Hospital Discharge

 20. Other (write in condition)