

OUTPATIENT PHARMACY SERVICES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook provides specific direction and procedures related to outpatient dispensing, outpatient clinical activities, automation, operational efficiencies, hand hygiene, and the appropriate handling and dispensing of drugs and supplies to outpatients.

2. SUMMARY OF MAJOR CHANGES:

a. Amendment dated February 6, 2020 clarifies statements in paragraph 5.b.(1) which requires providers to obtain a personal DEA registration.

b. Amendment dated August 20, 2019, clarified statements in paragraph 12.c.(6), which limits telephoning of prescriptions for filling at any pharmacy to the VA provider and prohibits the delegation of verbally communicating or telephoning prescriptions to other VA staff. It further clarified that transmission of written prescriptions by facsimile (fax) or similar electronic means may be delegated to other members of the healthcare team as appropriate.

c. This VHA Handbook provides new or expanded topic areas in the assessment of services for improved operational efficiency and has redefined outpatient clinical services to support the Patient Aligned Care Team (PACT) and Specialty Care Transformational Initiatives. In addition, there are specific statements on obtaining Drug Enforcement Administration Licensure for providers, prescriptions for Veterans outside of the United States, prescriptions for active-duty or discharged military, and the utilization of non-VA pharmacies.

3. RELATED ISSUES: VHA Directive 1108.01(1), Controlled Substances Management, dated May 1, 2019, VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015.

4. RESPONSIBLE OFFICE: The Chief Consultant, Pharmacy Benefits Management Services (10P4P) is responsible for the contents of this Handbook. Questions may be addressed to 202-461-6938.

5. RESCISSIONS: VHA Handbook 1108.05, dated May 30, 2006; Chapter 12, Pharmacist-conducted Patient Medication Counseling (M-2, Clinical Affairs, Part VII, Pharmacy Service); and VHA Directive 2008-028, dated May 16, 2008, are rescinded.

6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the last working day of June 2021.

June 16, 2016

Amended
February 6, 2020

VHA HANDBOOK 1108.05(2)

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Under Secretary for Health

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OUTPATIENT PHARMACY SERVICES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides specific direction and procedures related to outpatient dispensing, outpatient clinical activities, automation, operational efficiencies, hand hygiene, and the appropriate handling and dispensing of drugs and supplies to outpatients. **AUTHORITY:** 38 CFR § 17.38(a)(1)(iii).

2. BACKGROUND

a. The Pharmacy Service must be in compliance with relevant laws, regulations, policies and professional standards including The Joint Commission standards; privacy laws including the Health Insurance Portability and Accountability Act (HIPAA); VHA policies including Directives, Handbooks, practice standards and guidelines; technical bulletins of the American Society of Health System Pharmacists (ASHP); and the United States Pharmacopeia (USP). In addition, the Department of Veterans Affairs (VA) must follow all applicable federal and State laws including regulations concerning the dispensing of medications and the provision of Clinical Pharmacy Services to outpatients.

b. Prescription medication services are a major component of patient-centered outpatient services provided to eligible patients of VA. These services include: direct and indirect patient medication counseling and reconciliation; assurance of medication safety; formulary management; drug and supply dispensing services; and clinical pharmacist activities in both the primary care and specialty care settings. All clinical pharmacists have clinical responsibilities to ensure that these services are delivered to the Veteran.

3. DEFINITIONS

a. **Clinical Pharmacist.** A Clinical Pharmacist is the full performance level pharmacist position. For purposes of this handbook the term clinical pharmacist encompasses all licensed pharmacists assigned to positions described in VA Handbook 5005, Part II, Appendix G-15, Licensed Pharmacist Qualification Standard except for pharmacists serving in a developmental capacity at the GS-11 grade level. The role of each clinical pharmacist may differ based on their assignment and must be delineated in their functional statement or scope of practice, as appropriate.

b. **Clinical Pharmacist with a Scope Of Practice.** A clinical pharmacist with a scope of practice (SOP) is a clinical pharmacist who provides direct patient care and functions at the highest level of clinical practice, working with a high level of autonomy and independent decision-making within the parameters of their SOP, as defined by the individual medical facility, and performs functions as described in paragraphs 14 and 15. A clinical pharmacist with a scope of practice includes the clinical pharmacy specialist; however, a SOP may be included in the responsibilities of all levels of clinical pharmacists depending on their assignment as outlined in VA Handbook 5005.

c. **Comprehensive Medication Management.** Comprehensive medication management is defined as the standard of care that ensures each patient's medications (VA, non-VA, herbal, alternative, and over the counter medications) are individualized and optimized for the patient based on the patient's medical conditions; comorbidities; individualized patient parameters, such as age-related changes in pharmacokinetics and pharmacodynamics of medications; and patient-centered care factors. It includes the management of chronic diseases, the acute manifestations of these processes, and management of adverse events or reactions to medications. Comprehensive medication management includes components of medication therapy management but is a broader term that encompasses a larger spectrum of services that is provided by clinical pharmacists with a SOP as defined in VHA Handbook 1108.11, Clinical Pharmacy Services.

d. **Patient's Agent.** The patient's agent is a family member or caregiver who has been identified by the patient to act on the patient's behalf.

e. **Licensed Pharmacist.** A licensed pharmacist is a pharmacist licensed by a State, commonwealth, or territory of the United States.

f. **Oral Nutritional Supplementation.** Oral nutritional supplementation is the process of increasing oral intake by the addition of nutrients and calories to compensate for a nutritional deficit caused by inadequate consumption, increased requirements, or excessive losses.

g. **Sentinel Event.** A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

h. **Scope of Practice.** A SOP includes the clinical pharmacist's medication prescriptive authority, as well as a description of routine and non-routine duties to be performed, expectations, and the general areas of responsibility as outlined in VHA Handbook 1108.11, Clinical Pharmacy Services. The SOP permits a high level of autonomy and independent decision-making when performing the authorized duties but requires collaboration with the healthcare team for the overall care of the Veterans.

4. SCOPE

a. All outpatient pharmacy services are to be provided in a safe, appropriate, timely, efficient, and cost-effective manner which is patient-centered and provides the most clinical benefit to patients through optimal medication-related outcomes. The assurance of medication safety and positive outcomes are priorities for outpatient pharmacy services.

b. All licensed pharmacists, or designees, must offer prescription education to patients and/or a patient's agent on all new prescriptions dispensed from the outpatient pharmacy. This includes relevant verbal education and written materials, including

those mandated by the Food and Drug Administration (FDA) under the Risk Evaluation and Mitigation Strategies (REMS) programs and FDA MedGuides. Patient education for renewed or refilled prescriptions should be available at the request of the patient or the patient's agent, but is not mandated.

c. Outpatient prescriptions, with the exception of medical and surgical supply items, must be filled under the supervision of a licensed pharmacist and checked by a licensed pharmacist prior to issuance to the patient or the patient's agent. The check by a licensed pharmacist may be substituted by technology when a sealed manufacturer's bottle or a sealed bottle or package produced by an FDA licensed repackager is being dispensed through automated equipment in a Consolidated Mail Outpatient Pharmacy (CMOP) setting. The CMOP technology must incorporate barcode scanning verification of the sealed vial or package and the label applied to the vial or package. Appropriate quality assurance checks of the automation are required to ensure patient safety. Medical and surgical supply items (e.g., those items found in VA Drug Class Codes XA000-XA900) must, however, be ordered by prescription for accounting and review purposes.

d. It is the goal of the VA pharmacies to have good customer service and waiting times of 30 minutes or less for the dispensing process, but only if this can be achieved without sacrificing patient safety, which is of the utmost importance. The time to process starts when the patient presents to the outpatient clinical pharmacist or the prescription processing is initiated in other settings, and concludes when the prescription is released for pick-up by the patient. In order to achieve this goal, outpatient pharmacies may establish VA medical facility policy that restricts or prioritizes which prescriptions are urgently needed for same day dispensing and which can be processed more efficiently through the mailout system. Strategies to accomplish this goal are outlined in the paragraph on operational efficiency (see paragraph 19).

e. Clinical Pharmacists (CP) are allowed to perform duties that are considered routine. However, depending on the nature of the function or the manner in which it is performed, the activities could result in the performance of patient care, requiring a SOP as described in VHA Handbook 1108.11, Clinical Pharmacy Services (see paragraph 15, Outpatient Clinical Services).

5. RESPONSIBILITIES

a. **VISN Director.** The VISN Director is responsible to ensure that VISN Telehealth services, which involve prescribing controlled substances, are aware of the Ryan Haight Online Pharmacy Consumer Act of 2008 and appropriately meet the requirements of that law when providing services.

b. **Medical Facility Director.** The medical facility Director is responsible for ensuring that:

(1) All VA providers who are authorized by their State licensing authority and VHA to prescribe Drug Enforcement Administration (DEA) controlled substances have a

personal DEA registration number. **NOTE:** *The fee-waived DEA registration for federal employees may only be used for VA work-related activities. Controlled substance prescriptions written by VA providers as part of their official duties in treating a Veteran may be filled at a non-VA pharmacy.*

(a) The VA institutional DEA registration number, in conjunction with the identifying provider suffix, may be issued to Locum Tenens physicians, VA residents and interns who cannot obtain a personal DEA number. **NOTE:** *The VA institutional DEA registration number, in conjunction with the identifying provider suffix, may only be used for VA work-related activities.*

(b) Certified Registered Nurse Anesthetists (CRNA) may use the VA institutional DEA registration number, in conjunction with the identifying provider suffix when their State of licensure does not permit obtaining an individual DEA registration. In these cases, the CRNA must not be enabled for E-prescribing of Controlled Substances (EPCS) in the outpatient setting or be issue outpatient prescription blanks.

(c) Newly hired VA providers who do not already have an existing DEA registration may use the facility DEA number with suffix until they receive their personal DEA registration provided they show evidence that a DEA application has been submitted; All VetPro, license and other checks have been performed without findings that would preclude the provider from obtaining a DEA registration and prescriptive privileges for controlled substances are consistent with State of licensure. Facilities must update the provider file and EPCS with the provider specific DEA number and expiration date once the provider receives it. **NOTE:** *A fee paid DEA registration may be used within VA if the DEA registration is from the same State the VA facility is located in and the provider is licensed in. DEA regulations do not permit a fee paid registration to be tied to an out of State license.*

(d) To provide standardization and ease of identification, it is recommended to use the provider's NPI number as the suffix. **NOTE:** *Some State Prescription Drug Monitoring Programs (SPDMP) have a limitation on the number of characters for the suffix that the software will accept.*

(2) For all practitioners authorized to prescribe controlled substances in the outpatient setting, their DEA registration number, DEA registration expiration date, and the listing of controlled substance schedules that the practitioner is authorized to prescribe are recorded to the VistA NEW PERSON File (#200) by VA medical facility personnel who are authorized to validate the practitioner's credentials. This activity must be performed using the "EPCSDataEntryForPrescriber" application in order to comply with DEA regulations in title 21 Code of Federal Regulations (CFR) 1311 requiring the use of two-factor authentication for the administrator that is setting up a prescriber's access to electronically prescribe controlled substances.

(3) Practitioners authorized to prescribe buprenorphine-containing medications, according to the requirements of the Drug Addiction Treatment Act of 2000 (DATA

2000), have their detoxification or maintenance number recorded through the same “EPCSDDataEntryForPrescriber” application 21 U.S.C. 823(g).

(4) Those facilities that support Home Based Primary Care (HBPC), Mental Health Intensive Case Management (MHICM), or other home-based programs must have a local medical facility policy that identifies the medical facility staff authorized to deliver and administer medications and medical or surgical supplies. A clearly defined and reviewable chain-of-custody and security for all medications must be included in such policy.

c. **Chief of Pharmacy Services.**

(1) **Deliveries.** The Chief of Pharmacy Services, or designee, is responsible for ensuring that:

(a) Pharmaceutical deliveries are reconciled as to what was ordered and what has been received, noting any discrepancies.

(b) The receiving invoice is signed and dated. VA Handbook 7002-1, Part 4, requires designated receiving individuals to accept and inspect all goods ordered and received.

(c) The Fiscal B09 report, Pharmacy Prime Vendor Line Item Report, is promptly reviewed and reconciled as to what has been received to ensure the VA medical facility pharmacy is making correct payments for what is received and there is documented evidence (signature and date of review) that this review and reconciliation has been done. **NOTE:** *The Fiscal B09 report is generated weekly and is similar to invoices that are processed through on-line certification process or purchase card statement, with the exception that it is a summary of several invoices. VA Financial Policy Volume XVI, Chapter 1 requires reconciliation of billing statements, verification of items ordered being received and certification as to accuracy including maintenance of supporting documentation (e.g., receipts, invoices, and packing slips).*

(d) Different pharmacy staff members place and receive an order (i.e., the same employee cannot place and receive a given order).

(2) **New Prescriptions.** The Chief of Pharmacy Services, or designee, is responsible for ensuring each new prescription for a medication or supply is assessed by a licensed pharmacist and includes:

(a) All direct communication with the patient or patient’s agent;

(b) Appropriateness of the drug, dose, frequency, route of administration, and patient instructions for use;

(c) A review for therapeutic duplications;

(d) A review for actual or potential allergies or sensitivities;

(e) A review of actual or potential interactions between the medications or supplies ordered and the other medications, foods, diagnostic agents, or supplies ordered for the patient;

(f) Therapeutic drug and laboratory monitoring;

(g) Any contraindications regarding medications or supplies ordered for the patient;

(h) Appropriateness of medications or supplies according to applicable criteria for use, clinical practice guidelines, or therapeutic indications for use;

(i) Adverse events associated with high-alert or hazardous medications according to regulation, accrediting agencies, or VA policy;

(j) Potential errors with look-alike and/or sound-alike drug pairs according to local medical facility policy;

(k) Communication with the patient or patient's agent regarding unanticipated outcomes or adverse events in accordance with applicable regulations, laws, accreditation requirements, and VA policy;

(l) Ensuring orders for supply items, such as diabetic supplies, enteral nutrition, wound care supplies, incontinence supplies or appliances, or ostomy supplies are ordered, measured, and fitted for the patient by a qualified provider as appropriate;

(m) Annotating indication for use on prescription orders, as applicable, and to the extent feasible;

(n) Locally filling orders for special needs patients, including but not limited to visually impaired patients, patients who require a specific brand of product not supplied by CMOP, or patients who experience repeated problems with mail delivery;

(o) Clarifying all concerns, issues, or questions with the individual provider before dispensing or transmitting the prescription to CMOP; and

(p) Any other issues or concerns identified during outpatient prescription ordering or medication profile evaluation.

(3) Processing of Consolidated Mail Outpatient Pharmacy Prescriptions.

Regarding the processing of CMOP prescriptions the Chief of Pharmacy Services, or designee, is responsible for:

(a) Transmitting outpatient prescription orders to CMOP in a timely manner.

(b) Transmitting prescriptions to CMOP with all required elements of a complete medication order including valid and current patient mailing address and prescription warning labels, as appropriate according to local medical facility policy.

(c) Ensuring that "as needed," titrating orders, taper orders, or range orders provide detailed, patient instructions for use with defined dose and interval parameters. **NOTE:** *CMOP does not accept outpatient prescription hold orders; automatic stop orders; resume orders; "as directed" orders; orders for investigational medications; or orders for compounded medications or admixtures not commercially available.*

(d) Investigating and resolving prescriptions cancelled back by CMOP in a timely manner. **NOTE:** *After resolution, the VA medical facility may either resubmit the prescription order to CMOP or fill locally, as appropriate.*

(e) Utilizing the CMOP National Web Application tool to "File a QA Report" (see <https://vaww.apps.cmop.va.gov/CMOPNationalWebApplicationv2/PostQARReport.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public.* Submit a report on all patient-related incidents associated with outpatient prescription orders processed by CMOP. It is the responsibility of the VA medical facility staff to supply adequate details regarding the incident and whenever possible, recover pertinent packaging, vials, and refill documents; forwarding these materials to CMOP for investigation. As appropriate, the VA medical facility staff participates in focused reviews or administrative investigations conducted by CMOP related to reported incidents.

(f) Immediately contacting the local CMOP Patient Safety Manager (PSM) when the VA medical facility becomes aware of a sentinel event associated with an outpatient prescription order processed by CMOP. The CMOP must review and analyze the reported event in accordance with VHA Adverse Drug Event policy. If the event in question is related to a CMOP dispensing activity and meets The Joint Commission definition of a "Reviewable Sentinel Event," the CMOP makes the determination as to whether the event is to be reported to The Joint Commission. As appropriate, the VA medical facility participates in focused reviews or administrative investigations conducted by CMOP related to reported incidents.

(g) Notifying CMOP of prospective inventory changes or inventory requirements for new or existing products at least 5 working days prior to transmitting a prescription order to CMOP.

(h) Ensuring VistA software and software patches required to effectively transmit outpatient prescription orders to CMOP and to receive back data from CMOP regarding the fulfillment of said orders are installed and maintained.

(i) Ensuring complete and accurate patient address information is included with all outpatient prescription orders transmitted to CMOP.

(j) Utilizing the CMOP National Web Application "File a QA Report" tool (see <https://vaww.apps.cmop.va.gov/CMOPNationalWebApplicationv2/PostQARReport.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public* to submit a report on all patient-related incidents associated with outpatient prescription orders processed by CMOP. This includes reporting of controlled substance prescriptions

mailed from CMOP but lost in transit, or those packages received by the patient with obvious tampering or damage.

(k) Coordinating the addition of new drug entries into the National Drug File (NDF). Items for CMOP dispensing must have a monthly utilization of ten unique patient fills for the requesting site.

(l) Educating VA medical facility staff and patients or the patients' agent on the role of CMOP in the VA outpatient medication fulfillment process.

(m) Providing a point-of-contact and participating in customer service calls with CMOP.

(n) Providing patient counseling, individualized patient education, or written patient information associated with outpatient prescription orders transmitted to CMOP as required by law, regulation, accrediting agencies, or VA policy.

(o) Ensuring items on The Joint Commission Official "Do Not Use" List are not included in patient instructions (e.g., SIG (an abbreviation for Latin word Signa meaning to write)) to be printed on prescription labels for orders transmitted to CMOP. The Joint Commission Official "Do Not Use" List is found at https://www.hnfs.com/content/dam/hnfs/tn/prov/news/pdf/Prov_News_10_2010_V6_I10.pdf.

(p) Ensuring requirements for Risk Evaluation and Mitigation Strategies (REMS) and FDA MedGuides associated with outpatient prescription orders transmitted to CMOP are met as required by law, regulation, accrediting agencies, or VA policy.

(q) Reviewing the outpatient pending file and CMOP status to ensure timeliness of service (see paragraph 14.b).

(4) **Clinical Pharmacy Program.** The Chief of Pharmacy Services, or designee, has the responsibility for ensuring that the Clinical Pharmacy Program (see paragraph 16) is:

(a) Designed with an organizational structure that supports interdependent and autonomous professional practice.

(b) Afforded adequate time for CP and CPS to accomplish direct and non-direct patient care activities.

(c) Provided with the needed guidance to support the expansion of clinical pharmacy practices through changes in policies, the creation of performance goals, and standardization of practice goals.

(d) Treated with equal importance as medication safety, operational, and VA National Formulary (VANF) issues in each Veterans Integrated Services Network (VISN).

NOTE: *This may require a designated Clinical Pharmacy leader at each VA medical facility.*

(e) Responsible for oversight of the comprehensive medication management process and medication safety program at the VA medical facility level.

(f) Maintaining evidence of competency validation, Professional Practice evaluations (PPE), and supporting documentation required to meet SOP oversight requirements as outlined in VHA Handbook 1108.11, Clinical Pharmacy Services. **NOTE:** *Competency evaluation and PPE may be performed by the Associate Chief of Clinical Pharmacy Services, clinical pharmacist preceptor, or other appropriate clinical pharmacist personnel.*

(g) Communicating clinical pharmacy practice and policy issues to the VISN Pharmacist Executives (VPE), the Clinical Pharmacy Program Office (CPPO); and when necessary, the Office of the Chief Consultant, PBM Services.

(h) Providing oversight for the professional practice of all clinical pharmacists, regardless of the organizational structure or service, including those working under an SOP. This includes, but is not limited to, competency assessment, functional statements, patient care responsibilities, SOP recommendations, and professional practice evaluations for clinical pharmacists with a SOP. **NOTE:** *Consideration should be given to incorporating the elements of pharmacy practice based on licensure, appropriate pharmacy staffing levels, professional standards, credentialing, academic and research initiatives, clinical and operational competency, formulary management, and medication safety.*

(5) VA Form 10-2577F, Outpatient Prescription Blanks. This controlled form must be ordered in sufficient amounts by each VA medical facility from the VA Forms and Publications Depot. The Chief of Pharmacy, or designee, is responsible for the storage and issuance of VA Form 10-2577F, in the following manner:

(a) In accordance with local policy, each VA medical facility must maintain perpetual records on the forms received, forms issued, dates of issuance, serial numbers (received and issued), person issuing these forms, and receiving party (e.g., provider, clinic, or service representative). Local VA medical facility written policy must define the "receiving party."

(b) The records must specify the representative and bed service, ward, clinic, or individual provider who has received prescription forms by sequential number. Once issued to a provider, the individual provider or authorized user is responsible for the security of the prescription forms.

(c) The records must be maintained in Pharmacy Service and reconciled monthly as a component of the monthly controlled substance inspection process. Any loss of VA Form 10-2577F, must be reported as a Controlled Substance loss (see VHA Handbook 1108.02). Records of all losses must be maintained and reviewed annually as a risk management indicator.

(6) **Person Class File Taxonomy.** In an effort to improve the accountability and maintenance of the VistA New Person file (file 200), and safeguard the prescription process, it is recommended that the Chief of Pharmacy Services, or designee, have access to VistA option 'Person Class Edit [XU-PERSON CLASS EDIT]'. Person Class File Taxonomy requires that each provider be assigned a code from the Person Classification file and that these assignments be reviewed and updated at least annually. The Chief of Pharmacy Services must assume the responsibility for updating the Person Class file taxonomy for clinical pharmacists, technicians, and other individuals in their service only, on an ongoing basis.

(7) **Filing Prescriptions.** Prescriptions must be filed in a manner that facilitates retrieval when verification of computer-based data is necessary. All non-current prescription documents must be disposed of in accordance with VHA Records Control Schedule 10-1 (RCS 10-1). Prescriptions for controlled substances must be filed as required in Directive 1108.01.

NOTE: *Archived records are "media neutral." Therefore, records that are required to be retained in accordance with the RCS 10-1 may be converted and retained in electronic media unless specifically prohibited in RCS 10-1.*

(8) **Prescription Refills.** Prescription refills for recurring and/or continuous need medications and medical supplies must be dispensed in accordance with the authorization of the provider. Local VA medical facility policy may further limit the number of refills to the next scheduled clinic visit. Prescriptions can be refilled only at the request from the patient or patient's agent and must not be automatically dispatched.

(9) **Prescriptions Renewal.** Prescriptions renewed by the provider must be evaluated and verified by a clinical pharmacist to ensure medication safety and to prevent unwarranted dispensing of additional medication if the patient has a sufficient supply on hand. When the provider is a clinical pharmacist with a SOP, they are prohibited from verifying their own prescription; another clinical pharmacist must review their orders.

(10) **Verbal Orders.** The receipt of verbal orders or acceptance of facsimile copies of outpatient prescriptions must be in compliance with federal law and VHA policy.

(11) **Patient Identification.** Two forms of patient identification are to be requested prior to dispensing prescriptions. One form of identification may be a verbal response communicating a specific personal detail such as social security number or address. Pharmacy staff must adhere to local VA medical facility guidelines for patient identification. **NOTE:** *Pharmacy staff should verify the patient's mailing address that is listed in the Computerized Patient Record System (CPRS)-Graphic User Interface (GUI); updating the information when appropriate.*

(12) **Avoiding Prescription Duplication.** In order to prevent patient medication errors and unnecessary costs associated with duplicate dispensing, it is important that

VA pharmacy sites notify other VA medical facilities of prescription duplication as Veterans relocate or travel for extended periods. The following processes have been established to accommodate those Veterans:

(a) Determine the time frame in which the patient will be receiving care at the VA medical facility;

(b) Create a note using the template and specific Pharmacy Title for documentation. PBM recommends a progress note titled "Pharmacy Duplicate Remote Medication," (see Appendix C);

(c) To cancel a prescription use the "Cancel Prescription POC, Pharmacy" page of the VA PBM Pharmacy Directory, and select the "Cancel Prescription POC, Pharmacy" view or filter the "Position Title" column by "Cancel Prescription POC, Pharmacy".

NOTE: This directory is located at:

<http://vawww.national.cmop.va.gov/PBM/Lists/Pharmacy%20Phone%20Directory/General.aspx?View=%7bB1CB3FAF-E39E-45B3-83A7-2F8F79BC60F6%7d&FilterField1=Telephone%5Fx0020%5FNumber&FilterValue1=Cancel%20Prescription%20POC%2C%20Pharmacy>. This is an internal VA Web site that is not available to the public.

(d) Locate the VA medical facility that has the active duplicate prescription;

(e) Click on the email address field to generate an email; ensuring that pharmacy staff adheres to all electronic privacy requirements. DO NOT EMAIL to any other email group that is not listed in the PBM Pharmacy Directory as a "Cancel Prescription Contact, POC";

(f) Enter the following information into the email:

1. Subject: Cancel/Hold Prescription;

2. Body: A patient previously assigned to the facility is now receiving medications from [enter the prescribing facility name];

3. Reviewing the pharmacy duplicate remote medication entered on ____ [insert date] ____ for specific information; and

4. Cancel the following prescription numbers ____ [list prescription numbers] ____.

NOTE: Once the email is sent, it should be received by the individual(s) identified at the previous facility.

(g) The "Cancel Prescription POC, Pharmacy" at the receiving facility is to review the progress note entered by the prescribing facility and take the appropriate actions. In general, it is recommended that the receiving facility cancel the prescription and enter a progress note; and

(h) The local medical facility policy may be created for holding and/or taking other actions on the duplicate prescriptions if canceling the prescriptions would contradict existing procedures that are implemented for patient safety reasons. **NOTE:** *Prescriptions may be reinstated in VistA by a clinical pharmacist, if necessary, using the Prescription Processing Package.*

(13) Prescription Medications or Medical Supplies Dispensed by Mail.

Prescription medications or medical supplies dispensed by mail delivery must be securely packaged and properly addressed according to the following:

(a) Oversight of these medications and supplies must be maintained by Pharmacy Service until such time that the mail carrier accepts the packages for delivery;

(b) Upon notification that mailed medications are not received by the patient, this occurrence must be documented in narrative section of the Veteran's medication profile;

1. In the event of a recurring loss, a process must be instituted for all prescriptions sent to that patient using registered, certified, or private mail, (Federal Express, United Parcel Service, etc.); and

2. When clinically appropriate, the patient's provider must be notified.

(14) Controlled Substances. VA pharmacies are authorized to fill and mail prescriptions including controlled substances Schedule II, III, IV, and V. Controlled substance prescriptions must be handled in accordance with Directive 1108.01, "Controlled Substances Management."

(15) Paperwork Disposal. All patient-specific paperwork utilized during the pharmacy dispensing process, including unused labels, must be shredded or properly disposed of in a manner to ensure the privacy of this information.

(16) Loss of Inventory. The Chief of Pharmacy Services is responsible for loss prevention of pharmacy inventory throughout the pharmacy including separated storage areas, any pharmacy warehousing, and Community Based Outpatient Clinic (CBOC) dispensing sites. The following is required to ensure completeness of this responsibility:

(a) Secured areas of the pharmacy are to be treated as limited access areas protected by a keyless entry system (see VA Handbook 0730).

(b) All visitors to the pharmacy and storage areas must be accompanied by a pharmacy staff member.

(c) In addition, the Chief of Pharmacy Services, or designee, must:

1. Review electronic access logs on a monthly basis to look for unusual trends, such as unexpected entry, staff movement, delayed exit, etc.;

2. Discuss loss prevention with the pharmacy staff at least yearly; and

(17) **Outdated or Returned Medication.** The Chief of Pharmacy Services is responsible for establishing local VA medical facility policy which prohibits the acceptance of any outdated or otherwise returned medications directly from the patient or their authorized representative.

d. **Chief Consultant, Pharmacy Benefits Management Services.** The Chief Consultant, Pharmacy Benefits Management (PBM) Services, or designee, is responsible for:

(1) Reconciling the receipt of prescription order transmissions from the VA medical facility to the CMOP Central Database (CDB);

(2) Accepting prescription orders from VA medical facilities only for the product marked in the VA NDF as available for transmission to CMOP provided the minimum utilization requirement is met. This minimum includes orders for nutritional supplements and medical and/or surgical supplies;

(3) Accepting only those prescription orders from VA medical facilities with the minimum data elements which are:

- (a) Pharmacy site;
- (b) Pharmacy telephone number;
- (c) Patient name;
- (d) Prescription number;
- (e) Original fill-date or refill-date;
- (f) Drug name;
- (g) Drug strength;
- (h) Drug quantity;
- (i) Patient directions for use;
- (j) Provider name;
- (k) Prescription expiration date;
- (l) Transmission number (TRN#);
- (m) Auxiliary label information; and
- (n) Number of refills remaining.

(4) Maintaining appropriate inventory levels to minimize out-of-stock situations and associated cancel-backs;

(5) Communicating with the VA medical facility pharmacy about problematic prescription orders within 7 calendar days of date received. Situations requiring clarification or order cancel-back to a VA medical facility pharmacy may include orders that are incomplete, unclear, or contain disallowed terms included in the current CMOP National DO NOT USE (DNU) List;

(6) Providing written patient information for product dispensed by CMOP as required by law, regulation, accrediting agencies, or VA policy;

(7) Providing generic product for filling of transmitted prescription orders except in circumstances when only brand name product is available or an approval by PBM exists;

(8) Ensuring prescriptions processed and dispensed by CMOP are accurate according to data provided in orders transmitted by the VA medical facility;

(9) Ensuring contents of parcels entered into the delivery stream by CMOP meet requirements to protect patient privacy as established by law, regulation, accrediting agencies, or VA policy. To prevent duplicate reporting, CMOP must report privacy violations associated with prescription orders processed by CMOP to the corresponding VA medical facility.

(10) Communicating regularly, as appropriate and in accordance with regulatory, accreditation, and VA requirements, with applicable VA medical facilities and VPEs regarding services provided by CMOP, up to and including resolution of issues associated with the provision of services;

(11) Promptly reviewing and analyzing externally and internally reported patient-related incidents associated with prescription orders processed by CMOP according to regulatory, accreditation, and VA requirements. CMOP conducts focused reviews or administrative investigations on reported patient-related incidents in accordance with regulatory, accreditation, and VA requirements and provides timely feedback to the reporter(s) of the incident and appropriate stakeholders. As requested and appropriate, CMOP participates in focused reviews or administrative investigations conducted by VA medical facilities concerning patient-related incidents associated with prescription orders processed by CMOP;

(12) Promptly notifying appropriate VA staff and stakeholders of quality issues related to services provided by CMOP;

(13) Reporting occurrences of suspected loss or diversion of controlled substances dispensed by CMOP as required by regulation, law, or VA policy, including notification to the transmitting VA medical facility when appropriate;

(14) Maintaining production levels with adequate capacity and effective utilization of resources;

(15) Ensuring timely processing and fulfillment of prescription orders transmitted to CMOP. For those orders filled by CMOP, average turnaround time should not exceed 48 hours from the time the order is accepted by CMOP;

(16) Maintaining a National CMOP web site accessible to VA medical facilities for purposes of tracking orders and providing product information including product identification and cost;

(17) Tracking package delivery status for prescription orders filled by CMOP. CMOP must collaborate with delivery system partners to mitigate and resolve delivery issues;

(18) Supporting VA medical facilities to meet VISN product cost initiatives by procuring the most cost-effective contracted products available in quantities necessary to meet demand;

(19) Maintaining accurate product cost files with readily retrievable information accessible to VA medical facilities;

(20) Monitoring authoritative sources for drug and medical or surgical supply recall notices including the quarantine of affected stock according to issued guidelines; and

(21) Providing patient-specific fulfillment information to VA medical facilities for recalled items as required.

6. OUTPATIENT PRESCRIPTIONS

a. Prescriptions are to be ordered electronically using CPRS, or when required (e.g., Controlled Substances other than those electronically prescribed using two-factor authentication compliant with DEA regulations, research medications, local medical facility policy, etc.), written on VA Form 10-2577F (see Appendix B), VA Prescription Form, or VA Form 10-1158, Doctor's Order Sheet. **NOTE:** *With the expansion of same day and outpatient treatment activities, the present VistA outpatient capability in CPRS does not meet the needs of the prescriber. This is evidenced when intravenous preparations are required in these settings. In the interest of patient safety, templated prescriptions (paper based or electronic), as an alternative prescribing mechanism, are supported for specialty areas such as hematology or oncology, having received the approval by the Pharmacy and Therapeutics Committee. With regard to controlled substance prescriptions requiring VA Form 10-2577F, an electronic version of the prescription may be transmitted using CPRS version 29 or later, and two-factor authentication obtained by use of a Personal Identity Verification (PIV) card and its associated Personal Identification Number (PIN).*

b. All prescriptions written on VA Form 10-2577F for dispensing medications must be completed in a legible manner by an authorized provider in accordance with local medication error prevention policies. These prescriptions must contain the following:

(1) Patient's full name;

(2) Social Security Number (SSN) last four digits (for internal prescriptions only);

(3) Patient's current address;

(4) Name of medication; **NOTE:** *The generic form is preferred.*

(5) Dosage form;

(6) Strength; **NOTE:** *The metric dosage is required.*

(7) Quantity;

(8) Specific directions, including indication for use when an agent may be prescribed for the treatment of multiple disease states; **NOTE:** *Directions for use such as "when needed" or "as directed" are not acceptable.*

(9) Refills, if indicated;

(10) DEA number, or local facility DEA number and assigned suffix, for controlled substances; and

(11) Patient's service status (e.g., service connected (SC), non-service connected (NSC) for the condition being treated). **NOTE:** Unapproved abbreviations cannot be accepted.

c. The provider must print or stamp the provider's name on the form, then sign and date the prescription. Only one medication may be prescribed on each "Security Prescription Form," VA Form 10-2577F. The use of a pre-signed prescription form is not authorized.

d. Generally, no prescription can be filled for more than a 3-month (90-day) supply of medication. No prescription may exceed 12 months of therapy (including refills). However, provided the total quantity dispensed does not exceed the total quantity originally prescribed, an extended fill of an available refill may be dispensed in certain unusual circumstances identified in local VA medical facility policy (e.g., a travelling Veteran with no established forwarding address, civilian contractors assigned to areas of military conflict, or when the minimum allowable dispensed quantities [e.g., blood glucose test strips] exceeds the 90-day limit).

(1) For some prescriptions, a 1-month (30 days) or less limitation may be established. These include, for example, controlled substances (unless specified by Directive 1108.01), research medications, or any agent with a restriction not to exceed

30 days as specified by the VANF. In all instances, the P&T Committee must consider safety, patient care needs, and VISN resources when establishing such guidelines or restrictions.

(2) A prescription for Schedule II controlled substances may not be refilled; any additional quantities must be dispensed under a new prescription. In emergency situations, as defined in 21 CFR 290.10, a Schedule II controlled substance may be dispensed in limited amounts, pursuant to an oral prescription from the prescribing practitioner that is reduced to writing by the clinical pharmacist, and followed within 7 days by a written prescription from the prescribing practitioner 21 CFR 1306.11(d).

(3) Prescriptions for controlled substances in Schedules III-IV may be refilled up to five times in 6 months. Unless prohibited by State law, the clinical pharmacist may dispense an additional refill of the original prescription for Schedules III-IV controlled substances, through an oral refill authorization from the prescribing practitioner, provided the total quantity authorized does not exceed five refills or extend beyond 6 months from the date of the original prescription.

(4) Schedule V controlled substances may be refilled as authorized by the prescribing practitioner.

e. Prescriptions written by one VA medical facility for dispensing by another VA medical facility are discouraged. The VA medical facility of the provider prescribing the medication or supply item is responsible for all dispensing. This does not apply to prescriptions written at a physically separate location (e.g., the parent facility's CBOC) of the same facility.

f. A Medication Refill Request is generated by VistA to provide a convenient method for the Veteran to request refills of the Veteran's medications and medical supplies. Other methods for requesting refills may include using the telephone refill line and/or the internet by using My Health_eVet.

g. The use of the outpatient pharmacy label reprinting function needs must be limited by local medical facility policy to as few people as possible. Currently there is no way to limit this function in the outpatient pharmacy software. The outpatient pharmacy supervisor must manually monitor the audit logs in VistA at least monthly and more frequently if necessary to ensure the reprint function is correctly used.

h. In those instances where prescriptions are not entered directly into CPRS such as during emergency downtimes, or for non-VA (Fee) Care and controlled substances, the pharmacy service must develop a mechanism to store original prescription records in accordance with the disposition requirements set forth in Section XV of Records Control Schedule 10-1, <http://www.va.gov/vhapublications/rcs10/rcs10-1.pdf>. In addition, ordering and dispensing information must be recorded in the patient's medication history. All patient medications received from VA, or from outside VA, must be available for reference and review.

i. **Marijuana Programs.** VHA policy does not administratively prohibit Veterans who participate in State marijuana programs from also participating in VA substance abuse programs, pain management programs, or other clinical programs where the use of marijuana may be considered inconsistent with treatment goals. While patients participating in State marijuana programs must not be denied VA services, the decisions to modify treatment plans in those situations need to be made by individual providers in partnership with their patients. VHA Directive 2011-004, *Access to Clinical Programs for Veterans Participating in State Approved Marijuana Programs*, or subsequent publication.

j. **Non-medication Protocols.** Although medications may only be prescribed by providers authorized by law or VA regulation, which includes physicians, dentists, advanced practice registered nurses (APRNs), physician assistants (PA), or clinical pharmacists with an SOP that contains prescriptive authority for medications, non-medication protocols intended for use by non-providers (such as registered dietitians (RD), pharmacy technicians, and registered nurses (RN)) may be utilized in the outpatient setting only if they meet the following criteria:

(1) The term non-medication refers to non-medication products such as oral nutritional supplementation, expendable supplies, wound care and ostomy products that would not be defined as a drug per the FDA, see www.fda.gov. **NOTE:** *All legend drugs, over-the-counter medications, and herbal or alternative medications would be classified as medication and not permitted in non-medication protocols. In future versions of CPRS, it will be possible to grant a non-provider the privileges of ordering supplies without also granting them the ability to place medication orders. With this feature, the non-provider will be able to order items from VA Drug Class Codes XA000-XA900 (supply items), XX000 (Miscellaneous Items) and within DX900 (Other Diagnostics), those products marked as SUPPLY in the VistA DEA, SPECIAL HDLG field. Facilities will be able to further exclude selected items from the Supply-Ordering process by marking them as 'Quick Order Only.*

(2) The VA medical facility must have a policy that outlines the use of non-medication protocols and contains elements related to their use and oversight.

(3) A non-medication protocol must be utilized to improve the provision of care when ordering these non-medication products (e.g., a registered dietitian may be authorized under a VA medical facility policy to order oral nutritional supplementation).

(4) The use of non-medication protocols must be agreed upon and approved by the P&T Committee, corresponding Service Chiefs, and the appropriate approving body such as the Medical Executive Committee (MEC) or Clinical Executive Board (CEB).

(5) All items authorized on the non-medication protocol must be prescribed in accordance with local medical facility or VISN policy as defined in the VANF process and must be developed and approved in accordance with national guidelines. VISN or VA medical facility policy must restrict, or exclude, selected medical supply items to assure safe and cost effective use.

k. All VANF medications and medical supplies must be provided to eligible Veterans when a prescription is completed by a VA authorized provider who is licensed to practice their profession in a State, commonwealth, or territory of the United States provided they follow established Criteria-for-Use and established prescribing guidelines.

l. VA medical facilities may establish local medical facility policies for transmission and/or receipt of verbal orders or for the acceptance of facsimile copies of outpatient prescriptions, in accordance with The Joint Commission standards. However, if adopted, the policy must be consistent with the following guidelines:

(1) Only a licensed pharmacist (or pharmacy intern authorized by a State to dispense controlled substances under the supervision of a clinical pharmacist licensed by such State) can accept the verbal orders following standard VA medical facility verbal order policy;

(2) The policy must adhere to all DEA regulations and must include appropriate processes to prevent diversion and ensure accuracy and accountability;

(3) Verbal orders can only be used in emergency situations; and

(4) To ensure accuracy, the clinical pharmacist (or pharmacy intern, where appropriately authorized), must immediately transcribe the verbal order and read back the order to the provider in accordance with local medical facility policy.

m. General and prosthetic medical supplies, determined to be expendable stock items required for outpatient care and treatment, must be dispensed on prescription (CPRS or VA Form 10-257F). Pharmacy Service is not responsible for filling prescriptions for non-expendable medical equipment.

n. Pharmacy Service may dispense refills for expendable supplies upon receipt of requests from patients with continuing eligibility for a period not to exceed 1 year from the date of the last signed order. Expendable stock items include, but are not limited to:

(1) Catheters;

(2) Colostomy sets;

(3) Ileostomy sets and/or supplies;

(4) Plastic and rubber gloves;

(5) Skin preparations and powders;

(6) Urinal bags and drainage supplies; and

(7) Incontinence supplies.

o. Any loan or transfer of medications, medical supplies, etc., to other agencies or VA medical facilities must be accomplished by the Chief, Office of Acquisition, or designee. In certain emergency situations, Pharmacy Service with assistance and advice from Acquisitions may be authorized to obtain from, or provide to, another medical facility on short notice. Appropriate records of such transactions must be maintained.

7. MEDICATIONS FOR VETERANS IN LONG-TERM CARE FACILITIES INCLUDING NURSING HOME FACILITIES

a. **Medications for Veterans in Contract Nursing Homes.** When it is specified in the community nursing home (CNH) contract that medications and medical supplies are not included in the per diem rate, such medications and supplies must be provided by the VA medical facility that authorized the care in the CNH. **NOTE:** *Even if an authorized VA provider evaluates the Veteran and prescribes the medication, the contract needs to be examined to determine if the CNH is obligated to provide the medications.*

b. **Medications for Veterans in State Veterans Nursing Homes.** For information about the provision of medications to Veterans in State Veterans Nursing Homes, see VA Directive 2011-035, *VA Support for the Provision of Medications to Eligible Veterans in a State Veterans Nursing Home*, or subsequent policy. This Directive permits VA to provide drugs prescribed for Veterans in those nursing homes if authorized under Options 1, 3, or 4.

c. **Medications for Veterans in State inpatient Long-term Care Facilities including State Home Domiciliaries and State Mental Health Treatment Facilities, but not State Veterans Nursing Homes.** State medical facilities including State home domiciliaries and State mental health treatment facilities, but not State nursing homes, have a legal duty to provide needed health care to inpatients in their facilities. In accordance with 38 USC 1710(h) as implemented by 38 CFR 17.38(c)(5), VA does not provide medications to patients in these facilities unless the Veteran meets the requirements discussed in paragraph 8, under Aid and Attendance and/or Housebound.

d. **Medications for Veterans in Private Inpatient Long-term Care Facilities not under VA contract.**

(1) If a private provider prescribes medications for a Veteran in a private inpatient facility and VA is not paying for the care under a contract, VA must provide the medications prescribed if the Veteran meets the requirements discussed in section 8 of this Handbook under Aid and Attendance and/or Housebound.

(2) If a VA provider prescribes medication for a Veteran in a private inpatient facility and VA is not paying for the care under a contract, VA must provide the medication prescribed. **NOTE:** *Private nursing homes having contracts with private pharmacies under which a complete medication monitoring and delivery system is furnished, should nevertheless facilitate the Veterans obtaining medications from VA to the extent*

possible, but if the Veteran prefers to use the system provided by the nursing home we encourage the home to allow that.

e. VA must provide medications in unit-dose or individually-packaged compliance packaging, rather than vials, to comply with nursing home facility's medication management distribution system. **NOTE:** *Prescriptions may be dispensed in bulk if permitted by the State or nursing home in which the Veteran resides.*

f. In States that allow repackaging of VA prescriptions into unit-dose or individually packaged compliance packaging, VA will continue to supply the patient medications in bulk prescription medication vials. In these instances, VA is responsible for any additional costs incurred by the patient as a result of the repackaging in accordance with the terms of the contract between VA and the nursing home facility.

g. If the nursing home facility is unable to accept the VA's system of individually-packaged medications supplied to them, VA must use one of the following options to ensure the provision of needed medications to Veterans:

(1) VA must enter into a contract to reimburse the primary pharmacy provider, contracted by the nursing home facility, to allow for that pharmacy provider to supply medications in the same medication distribution system as all of their other residents; or

(2) VA provides for a contracted pharmacy which is able to meet the specific medication distribution system or dispensing needs of the nursing home facility.

8. PATIENT ABILITY TO RECEIVE PRESCRIPTIONS

a. Determining patient eligibility is a function of the Eligibility Office. Patient eligibility data is available in VistA and visible to the clinical pharmacist at the time of order entry or prescription processing. When prescriptions are written on VA Form 10-2577F, the provider must include the patient's eligibility status and, when appropriate, indicate if the prescription is for a Service Connected (SC) condition. Not all patients receive the same quantities of medications. In determining the quantities of medications that certain patients can receive, it may be necessary to consult VistA and/or VA Form 10-2577F when the provider uses the written form. The following categories of patients are authorized to receive medications or medical supplies in quantities not to exceed a 3-month supply (with three refills) per prescription; in some circumstances the supply provided must be less (e.g., VA (non-Veteran) employee prescriptions).

(1) **Authorized Absence.** Necessary medications and other supplies for treatment must be furnished to Veteran patients on authorized absence from the VA medical facility as determined medically appropriate by the prescribing physician. **NOTE:** *Authorized Absence has the meaning given to it in VHA Handbook 1162.02 Mental Health Residential Rehabilitation Program, or subsequent publication.*

(2) **VA Employee Prescriptions.** VA employee prescriptions must be limited to emergency treatment and minor ailments which interfere with the immediate ability to

perform duties. Medications cannot exceed a 72-hour supply. Larger supplies may be authorized for employees treated in conjunction with worker's compensation. **NOTE:** *These are VA employees who are not enrolled Veterans.*

(3) **Home-based Primary Care.** Patients who are furnished home-based primary care (HBPC) following an episode of VA-authorized inpatient care will be dispensed medications and medical supplies from a VA pharmacy.

(4) **Regular Discharge.** A patient given a regular discharge may be dispensed a supply of medications sufficient to maintain the prescribed regimen of care.

(5) **Aid and Attendance and/or Housebound.** Veterans who elect to obtain treatment at other-than-VA expense and are prescribed medications by a non-VA doctor of medicine or osteopathy, who is licensed to practice in the jurisdiction where the prescription is written, are eligible to receive the prescribed medications from a VA pharmacy if the Veteran receives increased compensation or increased pension (or formerly received increased pension but had it discontinued solely by reason of excess income, but only so long as such Veteran's annual income does not exceed the maximum annual income limitation by more than \$1000) by reason of being:

(a) In need for regular aid and attendance (A&A); or

(b) Permanently housebound (HB). See 38 CFR 17.96 for additional details.

(6) **Community Nursing Home.** When it is specified in the community nursing home (CNH) contract that certain services and supplies are not included in the per diem rate (e.g., medications and medical supplies), such services must be provided by the VA medical facility that authorized the care in the CNH. CNHs having contracts with private pharmacies under which a complete medication monitoring and delivery system is furnished, must be encouraged to provide the same service to Veteran patients.

(7) **Mental Health Residential Rehabilitation Treatment Program.** All outpatient prescriptions and pharmacy procedures for Veterans admitted to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) bed section (treating specialty 1K, 1L, 1M, 37, 39, 85, 86, or 88) must adhere to requirements specified in VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program, or subsequent policy. Particular attention should be paid to ensure that no more than a 7-day supply of any controlled substance is provided during the time that the Veteran is admitted to the MH RRTP, with other prescriptions limited to no more than a 30-day supply.

(8) **Outpatient Treatment for Service-Connected and Non-Service Connected Veterans.** When medications and medical supplies are prescribed for treatment of Veterans for SC and NSC conditions, those medications must be furnished by the VA medical facility providing the care.

(9) **Other Federal and Allied Beneficiaries.** When properly authorized, inpatient and outpatient services may be furnished to beneficiaries of other federal agencies with

whom VA has approved agreements or to those approved to receive care as allied beneficiaries. The current VA per-diem rate, or per visit rate, includes drugs administered to inpatients or in clinic, which are normally provided for VA beneficiaries under the same circumstances.

(10) **Other 1-month (no refills).** Medication may be prescribed for dispensing at VA pharmacies to non-Veterans under unusual circumstances when care is provided as a humanitarian service, with charges at rates established by 38 CFR § 17.102.

(11) **Against Medical Advice.** Prescriptions may be dispensed to Veteran patients who elect to leave the facility against medical advice (AMA) at the clinical discretion of the provider.

(12) **Incarcerated Patients.** Jails and prisons have a legal duty to provide needed health care to their inmates. In accordance with 38 USC 1710(h) as implemented by 38 CFR 17.38(c)(5), VA does not provide medications to inmates in these institutions unless the Veteran meets the requirements discussed above under Aid and Attendance and/or Housebound.

(13) **Active Duty Servicemembers.** When activated for military service, a Veteran who is in the National Guard or Military Reserve and who is receiving care from VA may receive up to a 3-month supply of medications with no refills at the time of deployment.

(14) **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).** Medications can be dispensed when a patient receives care directly from a VA medical facility. **NOTE:** *When CHAMPVA prescriptions are processed by the Meds-by-Mail program no copayments are assessed. However, a Cost share of 25 percent of the prescription cost applies when the patient utilizes the retail network (see 38 CFR 17.274).*

(15) **Non-VA Care.** Medications prescribed by a non-VA Care provider, when authorized by VA to provide care, can be dispensed by a VA pharmacy.

9. PRESCRIPTIONS FOR VETERANS OUTSIDE THE UNITED STATES

a. VA pharmacies will not ship medications or medical/surgical supply items outside of the United States (The United States includes United States Territories and possessions, the District of Columbia, and the Commonwealth of Puerto Rico). This prohibition extends to the Federated State of Micronesia, Palau and the Marshall Islands because they are outside the United States. **NOTE:** *The Foreign Medical Program (FMP) is a VA health care benefits program that pays for care of Veterans who are residing or traveling abroad and have VA-rated, service-connected (SC) disabilities. Medical services and supplies are paid for when medically necessary for the treatment of an SC disability or any disability associated with and held to be aggravating an SC disability, or as needed as part of a rehabilitation program under title 38, United States Code (U.S.C.) Chapter 31. Medical care provided in the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands, is paid for under the FMP (see 38 CFR 17.35). Medication required for treatment of SC*

conditions by Veterans living outside of the United States must be purchased locally and receipts submitted for reimbursement through FMP (see 38 CFR 17.35). However, Veterans with service-connected disabilities who receive outpatient care within the limits of the Manila VA Outpatient Clinic may be provided drugs prescribed by VA as part of that care at the Clinic or by mail (See 38 USC 1724(e)). **NOTE:** VA's medical benefits package does not cover drugs that are not approved by the FDA (see 38 C.F.R. 17.38). The FMP is administered by the VA Health Administration Center (HAC) at P.O. Box 469061, Denver, CO 80246-9061. See more at: <http://www.va.gov/purchasedcare/programs/veterans/fmp/#sthash.tvpJvrXg.dpuf>.

b. VA medical facility pharmacies and CMOPs can mail within the United States (to include United States Territories and possessions, the District of Columbia, and the Commonwealth of Puerto Rico) once they receive a prescription from a VA-authorized provider.

c. Medical facilities within the United States may fill a patient's outpatient medications prior to the normal dispensing date in the event that a Veteran will be traveling outside the United States. This may be done on a limited basis and requires consultation with the patient's VA provider prior to dispensing.

10. PRESCRIPTIONS FOR ACTIVE DUTY OR DISCHARGED MILITARY

a. Active Duty Servicemembers who are being provided care by VA are to be continued on the medications currently prescribed by Department of Defense (DoD) authorized providers in the absence of legitimate medication safety or appropriateness of care concerns. These DoD-prescribed medications must be provided regardless of whether or not they are listed on the VANF or whether or not their use is consistent with VA prescribing guidelines. **NOTE:** For guidance on Servicemembers who are activated see paragraph 8.a.(13).

b. When Active Duty Servicemembers are discharged from DoD and choose to receive their care from VA, VA providers are permitted to change medications, other than mental health medications that were previously prescribed by DoD providers, to VANF medications to ensure that medication use is consistent with VA prescribing guidelines. See VHA Directive 2014-02, Continuation of Mental Health Medications Initiated by DoD Authorized Providers, or subsequent policy issue, for guidance on changing these Veterans' mental health medications. It is imperative that these changes are clinically appropriate and carefully implemented to prevent avoidable problems.

11. SUPPLEMENTAL (EMERGENT NEED) AND NON-VA CARE PHARMACY SERVICES

a. Every effort must be made to utilize VA pharmacies for prescription services. When appropriate, arrangements can be made for emergency prescription services through a community pharmacy or the non-VA Care Program. These arrangements are to be made on a selective, individual patient basis, after careful determination of the

type and recurring nature of the prescription. Any pharmacy licensed by a State, commonwealth, or territory of the United States is eligible to accept and fill prescriptions for VA patients. The patient is reimbursed only if the patient has received prior approval in accordance with current local medical facility policy.

b. In addition to dispensing prescriptions, VA pharmacies must be used to fill authorized non-VA Care prescriptions in accordance with applicable law, VA regulations, and current VA policy in such a way that it is consistent with the needs and in the best interests of the patient. VHA Directive 1601, Non-VA Medical Care Program.

(1) When the clinical pharmacist and the prescribing provider authorized by VA to provide non-VA care are in disagreement as to the status of the prescription for non-VA Care, a reviewing VA medical facility provider must be consulted to validate that the medication was appropriate for the condition authorized.

(2) National and VISN formulary policy must be applied to non-VA Care medication orders. In most cases only formulary medications are to be provided; however, if the clinical justification is consistent with VA non-formulary policy, see VHA Handbook 1108.08, non-formulary medication may be dispensed. **NOTE: Eligibility issues must be resolved quickly so as not to unduly delay the processing of the prescription.**

12. UTILIZATION OF VA AND NON-VA PHARMACIES

a. All original prescriptions and refill requests for VANF medications that are identified for mail delivery must be processed for filling within 2 working days of receipt. Prescriptions which are not routine, such as those requiring clarification from the provider or non-formulary requests, may take longer.

b. The Chief of Pharmacy Services, or designee, must review the outpatient pending file and CMOP status to ensure timeliness of service. When a review indicates that a backlog of 7 calendar days exists, the following steps must be undertaken:

(1) Submit a dated report to the Medical facility Director outlining the period covered by the report, the number of unfilled prescriptions, and the circumstances causing the backlog. This report is to be filed weekly as needed until the matter is resolved.

(2) Provide to the Medical facility Director a report of actions taken to ensure that all patients receive their medications prior to running out of their current supply.

(3) Identify strategies and provide recommendations to correct the backlog.

(4) If the backlog remains for more than 4 consecutive weeks, the medical facility Director must submit a report to the VISN Director, VPE, and the Chief Consultant, Pharmacy Benefits Management Services citing the deficiencies, the circumstances involved, all corrective action(s) taken to date, and the projected timeline for resolution.

c. In certain instances VA may contract with private sector pharmacies to fill prescriptions written by authorized VA prescribers. Examples include: VISN or VA

medical facility contracted services to support CBOCs or rural health services. In such instances, VA staff must comply with the following:

(1) VA pharmacy staff are prohibited from transferring prescriptions to private sector pharmacies, either telephonically or by means such as a fax or e-mail;

(2) VA providers, authorized by their State license to prescribe, are permitted to write prescriptions for Veterans to be filled in private sector pharmacies (e.g., low-cost generic alternates when requested by the Veteran for economic reasons). Authorized prescribers must meet all prescribing requirements for the State where the prescriptions will be filled;

(3) All VA providers who are authorized by State license to prescribe DEA-controlled substances must use either their personal fee-exempt or fee-paid DEA registration number in order to prescribe medications for dispensing by non-VA pharmacies. When the provider is prescribing in accordance with official VA duties the provider may use their personal fee-exempt DEA registration. However, when acting outside of their official VA duties (i.e., in private practice, etc) a fee-paid registration number is required;

(4) VA providers must take action to cancel any active VA prescriptions for the same medications in order to prevent patients from receiving excessive quantities;

(5) VA providers must record non-VA prescriptions in the progress note and in the non-VA medications listing;

(6) Although it is not encouraged, VA providers who are authorized by their State license are permitted to telephone prescriptions to any pharmacy at the request of the Veteran, if they meet all requirements for the State in which the prescription is being filled. Telephoning must be done by the VA provider and cannot be delegated to other staff. Telephone prescriptions must be documented in the medical record to include pharmacy name, number phoned, and medication must be documented appropriately in the medical record (i.e., Non-VA medication section). **NOTE:** *This does not restrict the transmission of written prescriptions authorized by a VA provider by facsimile (i.e., fax) or similar electronic means to private pharmacies. The VA provider may delegate the faxing (or similar electronic means) of written and signed prescriptions to other members of the healthcare team as deemed appropriate at the local facility level;*

(7) VA Form 2577F must be utilized, in all instances, to prescribe DEA-controlled substances prescriptions when they are to be filled at non-VA pharmacies. **NOTE:** *This form may not meet the prescription requirements for every state. In such a case, local medical center policy may delineate how urgent prescriptions may be provided for dispensing by a non-VA Pharmacy;*

(8) It is an expected requirement of clinical care that VA providers obtain and record a complete list of all medications currently used by the patient. **NOTE:** *The non-VA medication file has been developed and should be used for the purpose of documenting medications obtained outside of VA; including prescription medication, over-the-counter*

medication, herbals, and nutraceuticals. It is particularly important that any medications prescribed by VA practitioners for outside fill are documented in this file.

d. Urgent (same day) prescriptions, resulting from telehealth services, will be provided in accordance with local VA medical facility policy.

13. OUTPATIENT CLINICAL SERVICES

a. The Chief of Pharmacy Services must identify the best use of VA pharmacy resources through process improvement, emphasizing the evolving clinical pharmacist roles. This includes:

(1) The use of automation;

(2) The identification of key roles for pharmacy technicians; and

(3) Opportunities to expand VA medical facility policy with safe medication practices to augment the assignment of clinical pharmacists to direct patient care activities.

b. Pharmacists and pharmacy technicians are key members of the health care team, assisting in the optimization of drug therapy, and improving medication safety and operational efficiency in the outpatient setting.

c. Pharmacists practice in a wide variety of settings including inpatient care, residential care, ambulatory care, community and home-based care, and specialty care; providing comprehensive medication management services to Veterans. Pharmacists in these settings, in accordance with local, VISN, and federal laws and regulations conduct routine outpatient medication activities including, but not limited to:

(1) Medication profile reviews;

(2) Medication counseling;

(3) Prescription processing;

(4) Extended fill and partials dispensing;

(5) Therapeutic substitutions;

(6) Non-formulary drug reviews;

(7) Formulary management;

(8) The identification and follow-up on medication-related problems identified during the production process; and

(9) Providing the required oversight of technical staff in all aspects of medication distribution.

14. CLINICAL PHARMACY SERVICES

a. It is the consummate goal of clinical pharmacy services to enhance medication-related therapeutic outcomes, improve medication safety, reduce inappropriate prescribing, and lower costs in an effort to improve patients' quality of life. Clinical pharmacy services have demonstrated that they significantly impact these areas, providing the mainstay of pharmacy practice in the modern era. Successful integration of clinical pharmacy services requires the focused attention of pharmacy leaders to provide a consistent care environment that ensures all Veterans can benefit from these services.

b. All clinical pharmacists can perform duties that are considered routine. However, depending on the nature of the function or the manner in which it is performed, the activities could result in the performance of patient care, requiring a SOP. **NOTE:** *For a description of these activities, refer to VHA Handbook 1108.11, Clinical Pharmacy Services.*

c. The clinical pharmacist with a SOP has responsibility for the provision of comprehensive medication management at the VA medical facility level. Pharmacists providing comprehensive medication management have demonstrated tremendous value to the health care team in areas such as anticoagulation, pain management, chronic (e.g., diabetes, hypertension, lipid control, cardiology) and specialty (e.g., infectious disease, hepatitis, nephrology) disease management, antimicrobial stewardship, and smoking cessation. It is important for the advancement of the profession that new clinical opportunities are evaluated and developed to allow for comprehensive medication management, based on patient care needs and the changing health care organization as described in VHA Handbook 1108.11, Clinical Pharmacy Services. **NOTE:** *It is recommended that a CPS with specialty expertise in oncology be added to the pharmacy service's organizational chart for all level 1 complexity medical facilities and those lower level complexity facilities with comprehensive oncology programs.*

15. PATIENT ALIGNED CARE TEAM PRINCIPLES FOR CLINICAL PHARMACISTS WITH A SCOPE OF PRACTICE (SOP)

Patient Aligned Care Team (PACT) principles for clinical pharmacists with a SOP are described in VHA Handbook 1101.10, Patient Aligned Care Team Handbook. To ensure clinical pharmacists work to the full extent of their licenses, competency, and SOP as described further in VHA Handbook 1108.11 the following principles should apply in the PACT setting:

a. PACT clinical pharmacists with a SOP are to be aligned under pharmacy services to establish practice standards, manage their duties, ensure competency, and provide consistent coverage.

b. Teams are recommended to have one assigned PACT clinical pharmacist with a SOP for every three provider panels (patient ratio of 1:3600); not including anticoagulation patients.

c. Anticoagulation support is best accomplished using the centralized support of an anticoagulation clinic which is recommended to be staffed, in addition to the team clinical pharmacist with a SOP, at a ratio of one anticoagulation clinical pharmacist with a SOP per five provider panels.

d. Clear processes for patient referrals are to be established to ensure PACTs are informed when a clinical pharmacist with a SOP is managing the patient's medications or disease state to goal, including appropriate referrals back to the primary provider. This must take place regardless of the mechanisms established for referral (e.g., warm handoff, formal consult, Medication Use Evaluation (MUE), or through registries and databases).

e. Pharmacists in PACT need to have established core schedules that are discussed with the team and adhered to. These core schedules are to have allocated time for face-to-face visits, Telehealth visits, telephone visits, PACT meetings, group education, secure messaging, trainee program participation, and walk-in visits where applicable. The following is a listing of standards for clinical pharmacist appointments:

(1) Clinic schedules are built on standardized appointment slots of 20-30 minutes for face-to-face visits (including real-time clinical video telehealth visits), and 10-15 minutes for telephone calls;

(2) Open appointment slots to accommodate same-day patient care are to be established with the PACT; and

(3) Clinical pharmacy clinics should be set-up using appropriate DSS identifiers, or stop codes described in VHA Policy and in accordance with PBM guidance and workload capture information found on the Clinical Pharmacy SharePoint at: <http://vaww.infoshare.va.gov/sites/ClinicalPharmacy/Clinical%20Specialty%20Pages/Worload%20Capture.aspx>. Whenever possible all clinical pharmacy clinics, operating under the oversight of the pharmacy service, should be given a primary stop code indicative of pharmacy (i.e., 160 stop code) when the clinical pharmacist is the main clinical provider responsible for that patient care encounter.

f. Pharmacy trainees, residents, and student pharmacists, when assigned to ambulatory care rotations, must be assigned to the clinical pharmacist. Oversight and supervision of trainees must be in accordance with VHA Handbook 1400.04, Supervision of Associated Health Trainees.

g. The Pharmacy Service designee must review all requests for leave by clinical pharmacists assigned to decentralized clinic locations. All approvals for annual and authorized leave must be in accordance with this policy and in support of timely patient access. Pharmacy service must ensure that cross-coverage of team functions and the patient care responsibilities of the clinical pharmacist are to be clearly communicated to

the PACT teams. **NOTE:** *Requests for clinical pharmacist planned leave are to be directed to the designated pharmacy leader and include communication to PACT leaders.*

h. PACT clinical pharmacists are encouraged to block planned leave on their appointment schedules, to reduce the workload requirements for cross-coverage. Pharmacy service site leaders (Chief, Supervisor or Program Director) must:

- (1) Ensure this policy is followed at all clinic locations;
- (2) Maintain a master schedule of PACT clinical pharmacist planned and unplanned leave and surrogate assignments;
- (3) Select alternative PACT clinical pharmacist coverage to ensure timely response to view alerts, e-mails, pages and acute patient care needs; and
- (4) Notify teamlets immediately of unplanned or sick leave and coverage strategies.

16. PATIENT EDUCATION

All patients, including those discharged from inpatient and residential facilities, are to be educated about their medications prior to, or at the time of, dispensing as stated in local medical facility policy. Such counseling needs to be tailored to the patient by focusing on their individualized drug regimen. Select activities that are required for the support of this effort are:

- a. Pharmacists are to reconcile the patient medication profile to:
 - (1) Identify poly-pharmacy, adherence and patient preference issues, and ensure guideline compliance;
 - (2) Discuss the necessary drug information with the patient or patient's agent;
 - (3) Determine the potential for drug-drug and drug-food interactions and make recommendations to health care providers as appropriate; and
 - (4) Evaluate laboratory tests deemed necessary for monitoring the outcomes of medication therapy (such monitoring needs to be tailored to the individualized drug regimen of the patient).
- b. Pharmacists are to review the patient medical record for the presence of allergy information and the potential for adverse drug events prior to the dispensing of medication to the patient.
- c. Pharmacists are to evaluate the medication order for appropriate dosing, taking into account the renal and hepatic function of the patient, in addition to other parameters related to patient-specific needs.

d. Pharmacists need to view non-VA and remote medications in VistA to ascertain if the patient is receiving medications from other locations.

e. Pharmacists are to review the provider's care or discharge plan in CPRS for errors, omissions, redundancies, etc.

17. OPERATIONAL EFFICIENCIES

a. VHA pharmacy leaders are responsible for being good financial stewards, ensuring that resources allocated to pharmacy service are being utilized in a manner that delivers maximum benefit to the patient and guarantees safety, proper medication use, and the delivery of clinical care that closes gaps in any unmet patient needs.

b. The following strategies have been shown to free up clinical pharmacist staff to take on additional clinical roles within PACT and Specialty Care, demonstrating improvements in Veteran care, medication safety, and overall cost-per-patient. They are to:

(1) Institute and enforce local medical facility policy which limits routine refills at the pharmacy outpatient window. This action has been demonstrated to decrease waiting times for patients who have new prescriptions, urgent needs, are homeless, being discharged from the hospital or are out of medications.

(2) Consider a business plan approach to limiting the number of outpatient pharmacy dispensing sites within the VA medical facility and centralize staff to one location where permissible.

(3) Establish a local contract for retail pharmacy dispensing of starter supplies of urgent medications (e.g., antibiotics, pain medications, etc.) while decreasing overall cost of inventory, space, and staff. This has been shown to be particularly effective at CBOC locations.

(4) Assess all activities currently being performed by clinical pharmacists that can be transferred to pharmacy technicians; this allows for reassignment of work in the most cost effective manner. This activity enables the expansion of clinical pharmacy services to PACT and specialty services where the clinical pharmacist can practice at full-practice capability. Activities for which pharmacy technicians should be staffed instead of clinical pharmacists include:

(a) Conducting ward inspections;

(b) Controlled substance inventory and distribution with the exception of checking prescriptions for outpatients and signing of appropriate records (see Directive 1108.01);

(c) Inventory management, acquisitions, and the drug accountability process for the medical center;

(d) Assisting with medication reconciliation;

- (e) Intravenous (IV) medication preparation;
- (f) Screening of non-formulary and prior authorization medications for review;
- (g) Medication Use Evaluation and quality assurance-related activities;
- (h) The purchasing of pre-made or pre-packaged products despite the sometimes higher unit cost as there can be enhanced return-on-investment resulting from the redirected clinical pharmacy activities; and
- (i) Unit-dose dispensing without a clinical pharmacist check, utilizing the tech-check-tech process. **NOTE:** *Where identified, the Chief of Pharmacy Services should strongly support the conversion of one clinical pharmacist position to multiple technician positions in order to accomplish activities related to the recommendations in this paragraph.*

18. WORK SPACES AND HAND HYGIENE

- a. Work spaces where medications are prepared and processed are to be kept clean, orderly, well-lit, and free of clutter, distraction, and noise. Adequate and secure space should be provided as outlined in the Office of Acquisition Logistics and Construction Design Guides, under the Outpatient Pharmacy Section at <http://www.cfm.va.gov/til/dGuide.asp>. In addition, food and drink are prohibited in any work area where medications are prepared or processed; eating and drinking must be confined to those areas of the pharmacy where it is not prohibited.
- b. Hand hygiene, a consideration in pharmacy practice and management, and other hygienic and procedural practices associated with preparing sterile compounded medications is described in USP 797, see <http://www.usp.org/around-world/usp-sites/us-headquarters>. Hand hygiene practices for those who provide direct patient care are described in the Centers for Disease Control and Prevention (CDC) Guideline for Hand Hygiene in Healthcare Settings at <http://www.cdc.gov/>.
- c. Pharmacy staff assigned to clinic responsibilities must adhere to hand hygiene practices.
- d. Pharmacy staff packaging outpatient medications and preparing non-sterile products for distribution to patients, must adhere to the aspects of hand hygiene relevant to pharmacy practice.
- e. Pharmacy staff must wash their hands with antimicrobial soap and water (or alcohol based antimicrobial hand rub) in the following situations:
 - (1) Whenever hands are visibly soiled;
 - (2) Prior to starting and returning to work after leaving the pharmacy area;
 - (3) After any significant patient contact;

- (4) Before donning gloves as required by a given pharmacy activity;
- (5) After the removal of gloves;
- (6) After coughing, sneezing, or using a tissue or handkerchief;
- (7) After visiting the bathroom; and
- (8) Before eating.

NOTE: *Eating and drinking must be confined to those areas of the pharmacy where it is not prohibited.*

f. Risk levels of all areas must be assessed where sterile preparations are compounded. All compounded sterile preparations (CSP) must be accurately identified, measured, diluted, and mixed and be correctly purified, sterilized, packaged, sealed, labeled, stored, dispensed, and distributed in compliance with USP 797 provisions (entitled "Pharmaceutical Compounding, Sterile Preparations"). In addition, the compounding of non-sterile preparations must meet acceptable standards of strength, quality, and purity with appropriate packaging and labeling in accordance with USP 795 provisions (entitled "Pharmaceutical Compounding, Non-sterile Preparations").

g. Artificial fingernails or extenders are not permitted for pharmacy staff that compound sterile preparations or provide direct, hands-on care to patients.

h. The Chief, Pharmacy Service, must ensure that disposable gloves, antimicrobial soap, alcohol-based hand rub, and hand lotion designed for use in health care settings are made available in all pharmacy work environments.

19. AUTOMATED PHARMACY SYSTEMS

a. Automated pharmacy systems, utilized in pharmacies to improve medication safety and the efficiency and accuracy of the dispensing process, include, but are not limited to mechanical systems that perform operations or activities (other than compounding or administration) relative to the storage, packaging, dispensing, or distribution of medications. These devices may collect, control, and maintain all transaction information.

b. Automated pharmacy systems must include standardized HL-7 interface with the VistA computer systems.

c. Pharmacy service must establish performance requirements for the manufacturer, pharmacy service personnel, and the automated pharmacy system during and after implementation, including installation, workflow assessment, maintenance, and training.

d. Pharmacy service must establish local policies and procedures to define maintenance, troubleshooting techniques, performance and standardization of the

equipment, filling and/or restocking procedures, and device operations. These policies must be written to include:

(1) Minimum competency requirements for all personnel who have access to and/or operate the equipment; and

(2) Protocol on how drugs can be safely delivered from the automated distribution machine to the patient (the main area of concern is when multiple drugs are being delivered to multiple patients and the potential for errors).

e. These written policies and procedures must be in place prior to use of the equipment to ensure safety, accuracy, security, patient confidentiality, and to define access and limits to equipment and medications.

f. An ongoing quality assurance program that monitors performance of the Automated Pharmacy System, and that includes standards and required documentation, must be implemented in each Pharmacy Service.

g. A contingency plan in the event of a system, power, or process failure must be established in each pharmacy service. This plan must include who needs to be contacted and how medications stored in the system are to be secured and/or obtained. **NOTE:** *It is recommended that a system be established to determine: how to recognize when a system failure occurs or is imminent; how to compensate to protect patient safety when failures occur; and how to get failures corrected expeditiously.*

h. Patient confidentiality must be ensured and maintained in all pharmacy service environments in accordance with HIPAA and other privacy standards. Safeguards must be established to prevent “outside” or inappropriate staff access to patient-specific information.

20. VETERANS HEALTH INFORMATION SYSTEMS TECHNOLOGY ARCHITECTURE (VISTA) MAINTENANCE

a. The Pharmacy Informaticist (ADPAC) is responsible for the oversight of Pharmacy Automated Systems and VistA programs that directly support pharmacy operations. They are responsible for communicating with the Office of Information and Technology (OIT) specialists at the VA medical facility when problems or concerns arise. System downtimes or malfunctions must be reported through the remedy ticket process. The PBM Clinical Informatics Office may be contacted through Outlook email for assistance.

b. The ADPAC is responsible for coordinating the installation and maintenance of VistA software and software patches with OIT. These patches are required to effectively transmit outpatient prescription orders to CMOP and to receive back data regarding the fulfillment of said orders.

c. The ADPAC is responsible for maintenance and updating of the local VistA Drug Files, including mapping to the National Drug File.

d. The Local VistA Drug File is to be reviewed monthly to identify any products improperly coded, titled or costed and to take corrective action.

e. Requests for new product additions or problems with the Medication Order Check Healthcare Application (MOCHA) or other clinical content systems must be submitted to the PBM National Drug File team.

f. Access requirements for the above-listed responsibilities are defined in a VA memorandum between VHA and the OIT (see <http://vaww.sde.portal.va.gov/docctr/Memoranda/120321-005OP1-Pharmacy ADPAC Minimum Access Requirements.pdf>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

21. MEDICATION SAFETY

a. Medication safety must be a concerted VA medical facility effort coordinated by the Chief of Pharmacy Services in conjunction with the appropriate service representatives to ensure the VA medical facility identifies drug-related problems and implements measures leading to improvement.

b. Services or processes that may be utilized to successfully measure or improve medication safety are:

- (1) Computerized physician order entry;
- (2) Medication error reporting and multidisciplinary analysis;
- (3) Adverse drug event reporting and multidisciplinary analysis; and
- (4) Utilization of CP and CPS.

c. Clinical Pharmacists enhance medication safety through the following activities:

- (1) Pharmacist-based Anticoagulation Clinics;
- (2) Pharmacist-based Pharmacotherapy and other specialty clinics;
- (3) Multidisciplinary team meetings;
- (4) Concurrent medication reconciliation;
- (5) Pharmacokinetic dosing services;
- (6) Antibiotic surveillance services;
- (7) Diabetic teaching services;
- (8) Pain management services;

- (9) Non-formulary and restricted drug request reviews and approvals;
- (10) Medication Use Evaluation; and
- (11) Drug information services and pharmacy newsletters.

22. PBM FIELD GUIDANCE

PBM Field Guidance is intended to clarify current VA policy, educate field staff, and provide direction prior to or at the time of formal VA policy implementation. It is important that VA pharmacy managers review and incorporate these guidance documents into local medical facility policies and procedures, as appropriate. Information on updated PBM Clinical Pharmacy Practice Guidance can be accessed on the Clinical Pharmacy Practice SharePoint site available at <http://vaww.infoshare.va.gov/sites/ClinicalPharmacy/default.aspx>. **NOTE:** *Examples of PBM Field Guidance have been developed and issued to local medical facilities for the following topics: Pharmacist Administration of Intramuscular and Subcutaneous Injections; Scope of Practice; Professional Practice Evaluations for VA Pharmacists with Prescribing Privileges; Pharmacy Workload and DSS Guidelines (located on the DSS website at <http://vaww.dss.med.va.gov/> (this is an internal VA Web site that is not available to the public). Pharmacy Business Rules for PACT; Competency Assessment; Verification of Medication Orders Prescribed by Pharmacists; and Pharmacy Contact for Cancelled Prescriptions. **NOTE:** This is an internal VA Web site that is not available to the public.*

23. REFERENCES

- a. Public Law 105-33, section 4331, The Balanced Budget Act of 1997.
- b. Public Law 104-191, The Health Insurance Portability and Accountability Act of 1996.
- c. 42 U.S.C. 1320a-7b(f), *amended by* Pub. L. No. 114-115, § 8, 129 Stat. 3131, 3134 (2015), Criminal Penalties for Acts Involving Federal Health Care Programs.
- d. 42 U.S.C. 1320A-7, Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs.
- e. 42 CFR §§ 1000-1002, 1003, 1005, Office of the Inspector General-Health Care, Department of Health and Human Services.
- f. VA Financial Policy Volume XVI, Chapter 1.
- g. VHA Directive 1070, Adverse Drug Event Reporting and Monitoring, dated September 12, 2014.

h. VHA Directive 2011-004, Access to Clinical Programs for Veterans Participating in State-Approved Marijuana Programs, or subsequent policy issue, dated January 31, 2011.

i. VHA Directive 1108.01(1), Controlled Substances Management, dated May 1, 2019.

j. VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 15, 2019.

k. VHA Records Control Schedule 10-1 (RCS 10-1).

l. VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015.

m. VHA Handbook 1101.10(1), Patient Aligned Care Teams (PACT) Handbook, dated February 5, 2014.

n. American Society of Health-System Pharmacists (ASHP). ASHP Guidelines on the Safe Use of Automated Medication Storage and Distribution Devices. *Am J Health-Syst Pharm*. 1998; 55:1403-7.

o. American Society of Health-System Pharmacists. ASHP Guidelines on the Safe Use of Automated Compounding Devices for the Preparation of Parenteral Nutrition Admixtures. *Am J Health-Syst Pharm*. 2000; 57:1343-8.

p. American Society of Health System Pharmacists. ASHP Statement on the Pharmacists Role in Clinical Pharmacokinetic Monitoring. *Am J Health-Syst Pharm* 1998; 55:1726-7.

q. National Association of Boards of Pharmacy Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy August 2012.

r. United States Pharmacopeial Convention, Inc. United States Pharmacopeia 32-National Formulary 27. Rockville, MD: US Pharmacopeial Convention, Inc.; 2009:(USP Chapter <797>);318-354.

s. United States Pharmacopeial Convention, Inc. United States Pharmacopeia 32-National Formulary 27. Rockville, MD: US Pharmacopeial Convention, Inc.; 2009:(USP Chapter <795>); 314-318.

ACRONYMS USED IN THIS HANDBOOK

Acronym	Term
A&A	Aid & Attendance
ADPAC	Automated Data Package Application Coordinator
ADR	Adverse Drug Reaction
APRN	Advanced Practice Registered Nurses
ASHP	American Society of Health-System Pharmacists
CBOC	Community-Based Outpatient Clinic
CDB	Central Database
CDC	Centers for Disease Control and Prevention
CEB	Clinical Executive Board
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CMOP	Consolidated Mail Outpatient Pharmacy
CNH	Community Nursing Home
CP	Clinical Pharmacist
CPPO	Clinical Pharmacy Program Office
CPRS	Computerized Patient Record System
CPS	Clinical Pharmacist Specialists
DEA	Drug Enforcement Administration
DoD	Department of Defense
DSS	Decision Support System
FDA	Food & Drug Administration
FMP	Foreign Medical Program
GUI	Graphic User Interface
HAC	Health Administration Center
HB	House Bound
HBPC	Home Based Primary Care
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
LEIE	List of Excluded Individuals and Entities
MEC	Medical Executive Committee
MHICM	Mental Health Intensive Case Management
MOCHA	Medication Order Clerk Healthcare Application
MUE	Medication Use Evaluation
NDF	National Drug File
NSC	Non-service Connected
OIG	Office of the Inspector General
OIT	Office of Information & Technology


ACRONYMS USED IN THIS HANDBOOK (cont.)

Acronym	Term
OPPE	Ongoing Professional Practice Evaluation
OPT	Outpatient Treatment
P&T	Pharmacy and Therapeutics Committee
PA	Physician assistant
PACT	Patient Aligned Care Team
PBM	Pharmacy Benefits Management Service
PIN	Personal Identification Number
PIV	Personal Identity Verification
POC	Point of Care
PSM	Patient Safety Manager
RCS	Records Control Schedule
RD	Registered Dietitian
REMS	Risk Evaluation and Mitigation Strategies
RN	Registered Nurse
SC	Service Connected
SOP	Scope of Practice
TMS	Talent Management System
USP	United States Pharmacopeia
VA	Department of Veterans Affairs
VANF	VA National Formulary
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
VPE	VISN Pharmacy Executive

SAMPLE OF VA FORM 10-2577F, SECURITY PRESCRIPTION FORM

Security features are incorporated in this form. Form is green with black print. Face of form is Green in color with the words Department of Veterans Affairs throughout. On this form is an ink dot that will change color when your thumb is applied.

FULL NAME: _____
 ADDRESS: _____
 FACILITY NAME: _____
 ADDRESS: _____

 INK DOT
B VOID

Please check or circle appropriate block below:

AUTH ABSENCE ≤ 96 HOURS	AUTH ABSENCE > 96 HOURS	INPATIENT	EMP	NBC	PBC	A&A OR HB	CNH	SC	OPT NSC	OTHER FEDERAL
Refill: 1 2 3 4 5 Nonrefill										
Another brand, equal in quality, of the same basic drug may be dispensed, UNLESS checked.										<input type="checkbox"/>
Label with medicine NAME, STRENGTH and QUANTITY unless checked.										<input type="checkbox"/>
PROVIDER SIGNATURE						DEAVA NUMBER			DATE	

SAMPLE ONLY
 NOT TO BE REPRODUCED

SAMPLE PHARMACY DUPLICATE REMOTE MEDICATION FORM

 Title: PHARMACY DUPLICATE REMOTE MEDICATION

Patient: ZZDUCK,DAISY SUE
DOB: APR 18,1985

Transfer to Station: * [redacted]
Transfer to Station #: * [redacted]
Requesting Pharmacist: * [redacted]
Phone/pager: * [redacted]

Transfer from Station: * [redacted]
Transfer from Station #: [redacted]
Sent to Pharmacist (enter name or email group): [redacted]

The following prescriptions have been transferred to the above station:

RX#	Medication Name
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Additional information: