

CONTINUATION OF THERAPY

Including Emergency Refills of Insulin

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE:

- Per [ORS 689.645](#), a pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.
- Per [ORS 689.696](#), a pharmacist may prescribe and dispense emergency refills of insulin and associated insulin-related devices and supplies to a person who has evidence of a previous prescription from a licensed health care provider.
- Following all elements outlined in [OAR 855-115-0330](#) and [OAR 855-115-0335](#), a pharmacist licensed and located in Oregon may prescribe any non-controlled drug or device to a person who has evidence of a previous prescription drug or device from a licensed health care provider in order to:
 - Replace a damaged* prescription drug or device within the original duration of therapy; or
 - Extend a patient's current prescription drug or device (same drug/device, dose and directions) to avoid interruption of treatment.

*The Pharmacist must use their reasonable professional judgment as defined by [OAR 855-006-0005](#) to determine if the drug or device is damaged. This includes physical damage like broken containers or spills, chemical changes like discoloration or unusual odors, and damage from exposure to heat or moisture, which can affect the drug or device's effectiveness and safety.

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

- Utilize the standardized Continuation of Therapy Patient Intake Form (pg. 2)
- Utilize the standardized Continuation of Therapy Assessment and Treatment Care Pathway (pg. 3)
- Utilize the standardized Continuation of Therapy Prescription Template *optional* (pg. 4)
- Utilize the standardized Patient Informational Handout *optional* (pg. 5)
- Utilize the standardized Continuation of Therapy Provider Fax *optional* (pg. 6)

PRESCRIBING PARAMETERS

- **For Non-Insulin Medication, Medication Related Devices and Supplies:**
 - Quantity sufficient for the circumstances
 - Maximum quantity:
 - Damaged: May not exceed original duration of therapy
 - Extend: May not exceed a 60-day supply
 - Maximum frequency:
 - Damaged: No more than one replacement in a rolling 12-month period per medication
 - Extend: No more than two extensions in a rolling 12-month period per medication
- **For Insulin, Insulin Related Devices and Supplies (excluding pump devices):**
 - Quantity sufficient for the circumstances
 - Maximum quantity: Lesser of a 30-day supply or the smallest available package size
 - Maximum frequency: No more than three extensions in a calendar year (Jan 1- Dec 31)

PHARMACIST TRAINING/EDUCATION: None required.

Continuation of Therapy: Self-Screening Patient Intake Form (CONFIDENTIAL-Protected Health Information)

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

Background Information:

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

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

To Be Completed by a Pharmacist:

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

| | |
|--|--|
| Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: <input type="checkbox"/> Prescription Vial <input type="checkbox"/> Medical Record <input type="checkbox"/> Other | Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: <input type="checkbox"/> Prescription Vial <input type="checkbox"/> Medical Record <input type="checkbox"/> Other |
| Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: <input type="checkbox"/> Prescription Vial <input type="checkbox"/> Medical Record <input type="checkbox"/> Other | Drug or Device: _____ Directions: _____ Quantity: _____ + 0 refills Evidence: <input type="checkbox"/> Prescription Vial <input type="checkbox"/> Medical Record <input type="checkbox"/> Other |

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

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

RPH Signature _____ Date _____

Emergency Refills of Insulin or Insulin-Related Devices

Assessment and Treatment Care Pathway

(CONFIDENTIAL-Protected Health Information)

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

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

RECOMMENDED REGIMEN:

Medication or medication-related device or supply

Notes:

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

COUNSELING POINTS:

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

Continuation of Therapy Prescription

Optional-May be used by pharmacy if desired

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

Rx

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

Written Date: _____

Prescriber Name: _____ Prescriber Signature: _____

Pharmacy Address: _____ Pharmacy Phone: _____

Patient Information
Continuation of Therapy

Pharmacy Name: _____ Pharmacist Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

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

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

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

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

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

Follow-up and Next Steps

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

Provider Notification Continuation of Therapy

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

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

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

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

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

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

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

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

RPH Signature _____ RPH Name (Print) _____ Date: _____

Please contact us if you have any questions about the care provided to our mutual patient or if you would like to obtain additional information please contact the pharmacy. The prescription(s) was issued pursuant to the Board of Pharmacy [protocol](#) authorized under [OAR 855-115-0345](#).