Policy

Pharmacist Scope of Practice

Ver 2

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Click Here for
Definitions
Applies to

Policy Statement:
It is the policy of the Medical Staff that pharmacists may place orders in the medical record that relate to practices authorized by the Formulary Committee, Pharmacy and Therapeutic Committees and entity medical staff committees.

Purpose:
To define the pharmacist's scope of practice, as it relates to placing orders without a provider co-signature.

Definitions:
None

Procedure:

I. Pharmacists may place orders in the medical record when the orders pertain to the appropriate initiation of therapy (as requested by the provider), clarification of therapy orders such as drug dosage form or dosage units, monitoring of drug therapy or other requests of the provider. Orders may include, but are not limited to:

   A. Drug initiation, changes or discontinuation via an approved pharmacy policy
   B. Laboratory tests for serum drug levels, renal function or any other laboratory test required for appropriate medication monitoring:
      1. Pharmacist will clinically assess the necessity for laboratory results to manage medication therapy
      2. When deemed necessary, the pharmacist will order the appropriate P&T approved laboratory values (if not already ordered or available in the medical record) listed in the laboratory guideline (Table 1)
      3. For all labs not included in the guideline, the pharmacist will utilize professional discretion and only order those labs that are intended to guide medication therapy management
         a. The pharmacist will notify the provider, by either direct communication or via a Sticky Note, for laboratory orders not listed in the guideline
      4. When considering lab orders close to discharge, determine whether it can be completed in the outpatient setting
   C. Clarification of the patient's home medications

1. This may include clarification of missing components of orders (dose, route, formulation (SR, XL, etc) or frequency) or discontinuation of orders that the patient is no longer taking per reliable medication history. Clarifications should be supported by reliable sources based on the pharmacist's judgment

D. Discontinuation of nonessential home meds during hospitalization and herbal-homeopathic, herbal and alternative remedies
    1. If a provider enters an order for a nonessential medication included in a category listed in Table 2, the pharmacist may reject the order
    2. When a nonessential home medication is discontinued during hospitalization, the pharmacist will assist in addressing any questions/concerns from the patient
    3. If a therapeutic holiday for a medication listed in Table 2 is determined by the provider to be inappropriate, the prescriber should enter a notation in the administration instructions of the order that it should be continued during hospitalization
E. Orders needed for profile cleanup (e.g. discontinuation of duplicate orders, discontinuation of orders for pre-meds for procedures that have been discontinued or completed, discontinuation of orders that are no longer appropriate for the level of care, discontinuation of prophylactic anticoagulation orders when therapeutic anticoagulation is initiated, and discontinuation of orders for which the originally prescribed route of administration is no longer valid)
F. Clarification of MAR timing of medications to optimize the scheduling of medications. This may include aligning medication dosing times to minimize entry into patient rooms to preserve PPE and adjusting timing of medication orders when transitioning between agents or formulations based on the pharmacokinetics of the medications (for example when transitioning from parenteral to oral anticoagulation).
G. Automatic stop date of a 5-day maximum on all orders for ketorolac
    1. If the order is not written for a specific length of therapy, the pharmacist will place an automatic stop date of 5 days
H. Orders for combination products may be separated into Individual ingredients if in the professional judgment of the pharmacist the patient would benefit from receiving only one of the analgesics
I. Orders for existing drug therapies may be converted to an alternative route of administration. The pharmacist will consider available routes and indication for therapy in choosing the equivalent dose, route and frequency. If no acceptable alternative form of the medication exists, the pharmacist will contact the prescriber to obtain clarification.
    1. Pharmacists will intentionally convert parenteral medications listed in Tables 3 and 4 to the oral/feeding tube route for patients who meet specific inclusion criteria
        a. Patient has a functioning gastrointestinal tract as evidenced by:
            i. Receiving other oral/feeding tube medications
            ii. Receiving at least a full liquid diet or enteral feeds with minimum residuals
            iii. Patient is ordered to be "NPO except meds"
        b. Additional criteria for anti-infectives

i. Patient is clinically stable
ii. Absence of severe or life-threatening infections (endocarditis, meningitis, sepsis, osteomyelitis, intracranial abscess, bacteremia)
iii. Patient has received at least one dose of intravenous therapy
iv. Temperature < 37.8°C (100°F) for ≥ 24 hours
v. Decreasing WBC count (if applicable)

c. Specific exclusions:
i. Conditions compromising absorption of enteral medication (short bowel syndrome, obstruction, ileus, GI motility disorders)
ii. Severe mucositis
iii. GI bleed and not tolerating an enteral diet
iv. Severe nausea, vomiting and/or diarrhea
v. A strict NPO order

2. The pharmacist will conduct a daily assessment to ensure the oral therapy is tolerated
3. The provider may write "do not change to oral" or "DAW". The pharmacist will document the provider's intent to not convert the parenteral order to oral/feeding tube. The pharmacist will continue to assess the patient daily for potential conversion but will contact the provider if the potential for route conversion is identified.
4. Pharmacists may automatically convert back to IV administration for approved medications if the patient no longer meets inclusion criteria
5. Pharmacists may change any medication to an NG or feeding tube route if necessary, to meet patient medication needs.

J. For duplicative orders of a PRN medication and indication/age group that appears in Appendix A, the pharmacist will add clarifying language to the order as directed in the appendix.
1. For PRN medications listed in Appendix A that are ordered subsequently and the older order has not been utilized within the last 24 hours, the pharmacist will discontinue the older order rather than adding clarifying language

K. Pharmacists may adjust medication dose range orders for opioids when the upper end of the range is greater than two times the lower end of the range order. **[***NOTE opioid orders for end of life/palliative cares are exempt from this policy]**
1. Pharmacists will use the low end of the dosing range to guide compliance with the policy [For example: an order for oxycodone 5-15 mg every 4 hours PRN is ordered; the pharmacist will adjust the order to oxycodone 5 – 10 mg every 4 hours PRN].

L. A medication order with an interval or timed frequency placed for a non-boarded ED patient may be modified to a frequency of once

M. OTC products may be converted to the closest formulary stocked product at the site

N. Pharmacists may order scheduled or as needed oral bowel -regimens (Senna first, Miralax second) for patients on scheduled opioids or those requiring frequent doses of PRN opioids. Pharmacists will evaluate chart and only place order if there is no known diarrhea AND no known bowel obstruction.
    1. The pharmacist will connect with the patient's nurse to gather more information if it is not available in the chart
    2. This does not allow for ordering bowel regimens intended for the PR route (excludes suppositories and enemas)
    3. The pharmacist will notify the provider upon ordering

O. Pharmacist may change orders for scheduled OTC medications (excluding aspirin) or pain patches (excluding fentanyl) to PRN if patient refuses the medications for > 72 hours.
    1. Pharmacist will notify provider

P. Pharmacists may reject/discontinue orders for typical admission order set medications that are high risk or contraindicated
    1. Example: acetaminophen > 2g/day ordered in patients with liver dysfunction
    2. Example: ondansetron ordered for patient with prolonged QTc
    3. Pharmacist WILL notify provider so that provider can make alternate decisions if indicated

Q. <u>During a time of albuterol MDI shortage</u>, upon receiving an order for albuterol, the pharmacist should do the following:
    1. For albuterol metered dose inhaler (MDI) PRN being resumed from home PTA medication list:
        a. If the patient has their own inhaler, the pharmacist should change the order to reflect that the patient will use their own supply.
        b. If the patient does not have their own inhaler, and the patient is not in isolation (not a PUI, not COVID +), the pharmacist should switch to albuterol nebulization at the same frequency as the original order
    2. If albuterol nebulizations are ordered (either from home PTA med list or new order) for a PUI or COVID + patient that is capable of using a metered dose inhaler (not intubated or on respiratory support), the pharmacist should switch from nebulizations to metered dose inhaler at the same frequency. The pharmacist will check with nursing if it is not clear in the chart whether the patient would be capable of using an MDI.

R. Pharmacists who staff in critical care areas may follow the Critical Care Scope of Practice (See Appendix B)

S. Pharmacists will add the naloxone order panel for inpatients for a scheduled or PRN opioid order if naloxone is not currently on the patient profile. The naloxone order is verified as "Scope of Practice – No Signature Required" or comparable verification

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Resources:
none

References:
none

Table 1. Laboratory Guideline

Medication therapy	Laboratory order for monitoring
Aminoglycosides	Labs and levels for monitoring are defined in pharmacy guideline Aminoglycoside Dosing Service
Anticoagulants	Baseline and ongoing labs for anticoagulants are outlined in the Anticoagulation Medication Management Policy within the Inpatient Anticoagulation Lab Requirements chart
Anti-epileptics	1. Carbamazepine, levetiracetam, Phenytoin/fosphenytoin : obtain free and/or total level 2. Divalproex sodium/Valproic Acid: obtain free and/or total level, liver function tests, ammonia and platelets
Antifungals	LFTs at baseline and at least weekly
Second Generation (Atypical) Antipsychotics	1. Olanzapine: fasting blood glucose and lipid level at initiation of therapy, and periodically during treatment 2. Clozapine: a. Patients with risk factors for diabetes (e.g., obesity, family history of diabetes),obtain a fasting blood glucose testing at initiation of therapy, and periodically during treatment b. REMS program link
Daptomycin	Serum creatinine phosphokinase (CPK) at baseline and at least weekly
Diazepam	LFTs as appropriate for monitoring
Digoxin	Serum digoxin level with acute changes in renal function
Dofetilide (Tikosyn)	Serum creatinine, potassium and/or magnesium levels for evaluation of therapeutic efficacy, safety, and monitoring with drug interactions
Endothelin Receptor Antagonists (e.g. Bosentan, Letairis)	LFTs and serum or urine pregnancy tests (in female patients of child-bearing age) prior to dispensing if they haven't already been performed in the last 30 days as per manufacturer guidelines
Erythropoeisis-stimulating agents	Hemoglobin (Hg), if result not available within the last 7 days
Folic Acid	Same dose
Linezolid	Platelet count at baseline and at least weekly
Lithium	Serum creatinine, sodium or lithium level with acute changes in renal function and as appropriate for evaluation of therapeutic efficacy and monitoring with drug interactions
Metformin	Serum creatinine level at baseline or with any acute changes in renal function
Multivitamin	Oral multivitamin formulation
Parenteral Nutrition	When the physician has ordered pharmacy to adjust Parenteral Nutrition (PN) based on labs, additional PN labs may be ordered as required for safe and appropriate management outside of the standing orders
Propofol Continuous infusion	Serum triglyceride level at baseline and every 72 hours in patients receiving higher doses and/or duration greater than 48 hours
Quinolones	Blood glucose checks while on therapy

Renal Insufficiency	Serum creatinine if a patient is receiving a medication on the approved Medication Dose Adjustment list and there is no serum creatinine available, as defined by pharmacy policy Automatic Medication Dose Adjustment for Adult Patients
Thiamine	Same dose (patients receiving high dose for concerns of Wernicke's syndrome are not eligible for conversion)
Vancomycin	- Labs and levels for monitoring are defined in pharmacy guideline Vancomycin Dosing Service. - If not yet ordered within the last 72 hours (pharmacist will confirm by reviewing existing results and prior pending lab orders) MRSA Nares PCR (MRSAPC) may be ordered upon vancomycin consultation for respiratory infection to guide de-escalation of vancomycin. Pharmacist will notify provider that the order has been placed [Suggested language "FYI, RE PATIENT NAME and MRN, a MRSA Nares PCR has been ordered per Pharmacy Policy to assist with vancomycin de-escalation for respiratory indication. "]

Table 2. Nonessential Medications and Dietary Supplements

Medication therapy	Indication
Acne medications*	Acne
Allergy medications that are AS NEEDED**	Seasonal allergies
Auvi-Q® epinephrine auto-injector	Asthma/Anaphylaxis
Binosto® (alendronate)	Osteoporosis
Bisphosphonates and combination products with bisphosphonates (e.g., alendronate, etidronate, risedronate, ibandronate, tiludronate)	Osteoporosis
Calcitonin salmon nasal spray	Osteoporosis
Cyclosporine ophthalmic emulsion	Keratoconjunctivitis sicca
Enstilar® (calcipotriene and betamethasone foam)	Psoriasis
Epanova® (Omega 3)	Hypertriglyceridemia
Fluoride 1.1% toothpaste (e.g**.,** Fluoridex Daily Defense Sensitivity Relief®)	Supplement
Ivermectin Cr/lotion (Soolantra®)	Rosacea
Mirvaso® (bromonidine 0.33% gel)	Erythema of rosacea
Naftin® (naftifine HCl gel)	Athlete's foot
Nuvail® (polyurethane nail solution) 16%	Nail Dystrophy
Sorilux® (calipotriene 0.005% foam)	Psoriasis
Vascepa® (icosapent ethyl)	Hypertriglyceridemia adjunct
Vitamin, mineral, herb, botanical, amino acid, or dietary substance to supplement the diet except as approved by P&T as a formulary status medication	Supplement
Weight loss agents (e.g., orlistat, phentermine)	Weight loss

*Patients on isotretinoin may continue with their home supply while in the hospital

**Pharmacist must confirm that holding these medications is acceptable to patient during medication history

Table 3. Medications Eligible for Automatic IV-PO/FT Conversion for Adult Patients

Parenteral order	**PO/FT conversion** *Unless otherwise stated, use same frequency*
Acetaminophen (Ofirmev®)	same dose *For sites that only carry 325mg strengths, convert to the nearest dose available*
Azithromycin (Zithromax®)	same dose
Brivaracetam (Briviant)	same dose
Ciprofloxacin (Cipro®) 200mg	250mg (do not use liquid product for feeding tubes)
Ciprofloxacin (Cipro®) 400mg	500mg (do not use liquid product for feeding tubes)
Clindamycin (Cleocin®) 600mg q8h	300mg TID (450mg if patient >80kg)
Clindamycin (Cleocin®) 900mg q8h	450mg TID *For severe infections, may use 600mg TID. Monitor for gastrointestinal tolerance*
Digoxin	same dose ***Interchange maintenance doses only**. Do not interchange loading doses*
Diphenhydramine (Benadryl®)	same dose
Doxycycline	same dose
Esomeprazole	same dose
Famotidine (Pepcid®)	same dose
Fluconazole (Diflucan®)	same dose
Folid Acid	Same dose
Lacosamide (Vimpat®)	same dose
Levetiracetam (Keppra®)	same dose
Levofloxacin (Levaquin®)	same dose
Levothyroxine	75% of previous dose *Resume previous PO dose as appropriate. If dose changes have been made during admission, assess dose in context of clinical picture and consult with provider as appropriate*
Linezolid (Zyvox®)	same dose
Metoclopramide (Reglan®)	same dose; use before meal frequency
Metronidazole (Flagyl®) q8-12h	same dose TID
Multivitamin	Oral formulation of multivitamin

Pantoprazole (Protonix®) 40mg injection	omeprazole 20mg OR pantoprazole 40mg
Phenytoin/Fosphenytoin 100mg PE	100mg ***Interchange maintenance doses only****. Do not interchange loading doses. Assess dose in context of clinical picture (i.e. levels) and consult with provider as appropriate*
Rifampin 600mg	same dose
Sulfamethoxazole/Trimethoprim (Bactrim®) 80mg TMP	80mg TMP *(patients receiving high dose IV- 15mg/kg/day TMP are not eligible for conversion)* *tablets/liquid to yield equivalent amount of TMP per day*
Thiamine	Same dose (patients receiving high dose for concerns of Wernicke's syndrome are not eligible for conversion)
Voriconazole (Vfend®)	same dose *may change* ***after initial two IV loading doses***

Table 4. Medications Eligible for Automatic IV-PO/FT Conversion for Pediatric Patients (30 days – 17 years old AND < 45 Kg)

Medication therapy	Approximate conversion factor	Usual parenteral dose	Equivalent enteral dose
Brivaracetam (Briviant) *– only in patients 16 years and older*	1 mg IV = 1 mg PO	50 mg per dose q12h	50 mg per dose BID
Ciprofloxacin	4 mg IV = 5 mg PO	18-30 mg/kg/day divided Q8H or Q12H	20-40 mg/kg/day divided BID
Digoxin (maintenance doses only)	1 mg IV = 1 mg PO	2.5-15 mcg/kg/day	2.5-15 mcg/kg/day
Diphenhydramine	1 mg IV = 1 mg PO	1 mg/kg/dose Q4-6H	1 mg/kg/dose Q4-6H
Doxycyline	1 mg IV = 1 mg PO	2-4 mg/kg/day divided Q12-24H	2-4 mg/kg/day divided Q12-24H
Esomeprazole	1 mg IV = 1 mg PO	0.5-1 mg/kg/day	0.5-1 mg/kg/day
Famotidine			
Fluconazole	1 mg IV = 1 mg PO	3-12 mg/kg/day Q24H	3-12 mg/kg/day Q24H
Levetiracetam	1 mg IV = 1 mg PO	10 mg/kg/dose BID	10 mg/kg/dose BID
Levofloxacin	1 mg IV = 1 mg PO	10 mg/kg/dose Q12-24H	10 mg/kg/dose Q12-24H
Levothyroxine (check home dose)	0.75 mg IV = 1 mg PO	1-7.5 mcg/kg/dose daily	2-15 mcg/kg/dose daily
Pantoprazole	1 mg IV = 1 mg PO	0.5-1 mg/kg/day	0.5-1 mg/kg/day
Ranitidine	1 mg IV = 2 mg PO	2-4 mg/kg/day divided Q6-8H	4-8 mg/kg/day divided BID

Appendix A
When more than one PRN order by the same route of administration with the indication is active for a patient (in the absence of criteria defining how to choose between these medications) the pharmacist may automatically add the words "Offer first," "Offer second," etc. to the instructions of existing orders in the following order:

Antiemetics with a PRN indication "nausea/vomiting" or similar:

Pediatric	**Adult**	
	Oncology	**Non-Oncology**
Ondansetron	Prochlorperazine	Ondansetron
Diphenhydramine	Ondansetron	Prochlorperazine
Lorazepam	Lorazepam	Metoclopramide
Promethazine	Promethazine	Promethazine
Prochlorperazine	Metoclopramide	Lorazepam
Metoclopramide	Diphenhydramine	Diphenhydramine

Antihistamines (first generation) with an indication of "itching", "pruritis", or similar:

Adult:
1. Diphenhydramine
2. Hydroxyzine

(Call to clarify if patient is 65 years old or greater due to both agents being listed in the Beers Criteria.)

Antihypertensive medications:

When both hydralazine and labetalol are ordered for high blood pressure or identical BP parameters, add these words to the administration instructions in each order:**

"If heart rate greater than or equal to 60 bpm use labetalol first, if heart rate is less than 60 bpm use hydralazine first"

**This wording comes from an SBAR presented at the September 2015 Formulary Committee meeting. The information is available in our on-line formulary entries for hydralazine and labetalol.

Antimotility agents with an indication of "diarrhea", "loose stool", or similar:

Adult:

1. Loperamide (not to exceed 16 mg per day)
2. Bismuth subsalicylate
3. Diphenoxylate/atropine

Bowel stimulant agents with a PRN indication of "constipation" or similar*:

Adult Oral	Adult Rectal
Senna Bisacodyl Milk of magnesia Polyethylene glycol Magnesium citrate	Bisacodyl Fleets enema

* Note: If docusate is also ordered, recommend scheduling the medication or add clarifying language to use in
addition to a stimulant if constipation exists.

Expectorants and/or antitussives with an indication of "cough," or similar:

Adult:

1. Guaifenesin (single agent)
2. Dextromethorphan or dextromethorphan + guaifenesin
3. Benzonatate
4. Codeine or codeine + guaifenesin

Heartburn agents with a PRN indication “heart burn,” “GI upset,” or similar:

Adult
Calcium Carbonate (Tums)
Mylanta / Maalox
Famotidine

Nicotine withdrawal agents with a PRN indication “nicotine withdrawal,” or similar:

Adult
Nicotine gum
Nicotine lozenge

Sleep agents with a PRN indication “sleep,” “insomnia,” or similar:

Adult
Melatonin
Diphenhydramine
Temazepam
Zolpidem
Trazodone

Appendix B

Scope of practice expansion specific to Critical Care areas *[Note: this policy section has been reviewed and discussed amongst the critical care pharmacy clinical leaders at UMMC, FSH, FRH, LHE]*

I. Pharmacists may discontinue orders for vasopressors, sedatives, paralytics and continuous infusion analgesics if the plan to discontinue these agents per the primary team is clearly stated (in rounds/discussion/notes) yet they remain on the MAR and have not been used in 24 hours
II. Pharmacists may discontinue chlorhexidine oral care intubation orders once the patient has been extubated
III. Pharmacists may update the RASS goals in sedative orders -4 to -5 when a paralytic is initiated
    A. To align with all paralytic order administration instructions
IV. Pharmacists may order artificial tears when a paralytic is ordered
    A. Artificial tears ointment applied to both eyes every 6 hours scheduled