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ISMP
An ECRI Affiliate

Community/Ambulatory Care
ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

Numerous wrong dose errors with Paxlovid

PROBLEM: In the last few months, ISMP and the US Food and Drug Administration (FDA) have received numerous reports of wrong dose errors related to **PAXLOVID** (nirmatrelvir and ritonavir). Paxlovid is indicated for the treatment of mild-to-moderate coronavirus disease 2019 (COVID-19) in adults and pediatric patients (12 years and older weighing at least 40 kg) with positive results of direct severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. The dosing errors occurred at various points throughout the medication-use process, including prescribing or dispensing the wrong strength, improper renal dosing, and self-administration errors. A recent analysis of national oral antiviral (**LAGEVRIO** [molnupiravir] and Paxlovid) dispensing data through May 21, 2022, for the treatment of COVID-19 showed that 87% of these drugs were dispensed by pharmacies (www.ismp.org/ext/940). Therefore, the following information has major implications for pharmacists.

Paxlovid Packaging Configurations

Paxlovid is currently available in two configurations. For patients with normal renal function (estimated glomerular filtration rate [eGFR] equal to or greater than 90 mL/minute) or mild renal impairment (eGFR below 90 mL/minute but more than or equal to 60 mL/minute), Paxlovid is available in a carton holding 30 tablets contained in 5 daily-dose blister cards (**Figure 1**, page 2). Each blister card contains 4 nirmatrelvir tablets (150 mg each) and 2 ritonavir tablets (100 mg each). The dose, administered twice a day, in the morning and evening, is 2 tablets of nirmatrelvir (150 mg each, 300 mg total) and 1 tablet of ritonavir (100 mg). In January 2022, ISMP published a special alert related to Paxlovid safety risks (www.ismp.org/node/29033), in which we noted that **patients with moderate renal impairment** (eGFR below 60 mL/minute, but more than or equal to 30 mL/minute) **must take only 1 tablet of nirmatrelvir (150 mg) along with 1 tablet of ritonavir (100 mg) together, twice daily.** Patients with severe renal impairment with an eGFR below 30 mL/minute should not receive the drug.

When Paxlovid first became available, dispensing pharmacists needed to remove 1 of the 2 nirmatrelvir tablets for both the morning and evening doses from each of the blister cards before dispensing Paxlovid to patients with moderate renal impairment. In some reported cases, extra tablets were not removed for renal dosing, or, by mistake, pharmacies removed ritonavir instead of the nirmatrelvir component. To mitigate these dosing risks, in April 2022, cartons of Paxlovid for patients with moderate renal impairment became available with reduced-dose blister packages designed to provide just 1 tablet of nirmatrelvir (150 mg) along with 1 tablet of ritonavir (100 mg) to be administered twice daily (**Figure 2**, page 2). Instead of 30 tablets in the carton for patients with normal renal function or mild renal impairment, each carton contains just 20 tablets divided into 5 daily-dose blister cards for patients with moderate renal impairment.

Recently Reported Errors

Many of the recently reported errors have happened during patient self-administration and generally involved patients taking the wrong tablets (e.g., took 3 tablets of nirmatrelvir from the same blister card and no ritonavir, took 2 ritonavir tablets and 1 nirmatrelvir

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SAFETY briefs

HIGH-ALERT

Common workaround contributes to override of barcode alert. A specialty pharmacy filled a prescription for **JAKAFI** (ruxolitinib) 5 mg tablets with 15 mg tablets by mistake and shipped it to the patient. Jakafi is a kinase inhibitor used to treat myelofibrosis and polycythemia vera in adults, and graft-versus-host disease in patients 12 years and older. When the patient received the delivery, they noticed the tablets looked different and alerted the pharmacy. The prescription was written correctly by the provider for Jakafi 5 mg tablets, and it was entered correctly into the dispensing software; however, the label was incorrectly placed on the manufacturer's bottle of Jakafi 15 mg tablets. When the verification pharmacist scanned the product's barcode, they received an error alert. The pharmacist overrode the alert as he assumed the barcode scan did not work without recognizing than the wrong strength of the product was scanned.

The staff at this pharmacy had previously experienced barcodes on some products

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Nominations open for CHEERS AWARDS

Each year, ISMP honors individuals, organizations, and groups from various healthcare disciplines that have demonstrated an exemplary commitment to medication safety through innovative projects with an **ISMP CHEERS AWARD**. The **AWARDS** will be presented in December—more to follow on the celebration! Nominations for this year's **CHEERS AWARDS** will be accepted through **September 9, 2022**. ISMP accepts external nominations, including self-nominations. Please refer to **page 6** for a checklist of **DOs and DON'Ts** when submitting a nomination for a **CHEERS AWARD**. For details and to submit a nomination, visit: www.ismp.org/node/123.

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tablet for each dose, took the entire day's dose [6 tablets] at one time, took 2 nirmatrelvir tablets from one blister and 1 nirmatrelvir tablet from another blister for each dose). Dispensing errors involved providing the carton with reduced-dose blister packages intended for patients with moderate renal impairment to patients with normal renal function or mild renal impairment, or vice versa. Several of the reported errors involved improper renal dosing, such as prescribing or dispensing Paxlovid to patients with severe renal impairment. Other prescribing errors included ordering the standard dose for patients with moderate renal impairment and vice versa, prescribing the incorrect quantity (e.g., 30 tablets for moderate renal impairment dosing), providing directions to take 2 tablets twice a day in conflict with the instructions on the package prescribed, and not checking or asking patients about renal function or concomitant drug use to avoid drug-drug interactions.

Contributing Factors

Before the reduced-dose blister package for patients with moderate renal impairment became available, we mostly received error reports involving pharmacy staff failing to remove 1 of the nirmatrelvir tablets for each dose on all 5 blister cards and/or omitting auxiliary stickers (provided by the manufacturer) to alert patients to the altered packaging and removal of the unneeded tablets. However, even with the availability of the reduced-dose blister package for patients with moderate renal impairment, we continue to receive reports of Paxlovid dosing errors with the following contributing factors:

- The prescriber was unaware of the required dose adjustment needed for patients with moderate renal impairment
- The prescriber was unaware of the patient's renal function (or the patient's concomitant drugs to screen for drug-drug interactions; see a reported Paxlovid drug-drug interaction in our May 2022 newsletter)
- Prescribers' confusion about the two available packages and the number of tablets per regimen
- The new moderate renal impairment dose packaging may not be stocked in certain pharmacies
- Mix-ups between look-alike cartons of the standard and moderate renal impairment doses
  - The reduced-dose blister package and carton fail to note it is for patients with moderate renal impairment
- Confusion when referring to the tablets by their color or the blister package colors
  - Tablet colors are not visible in the blister packages
- Error-prone and inconsistent format of displaying Paxlovid in electronic health records (EHRs)
  - For example, the nirmatrelvir dose was listed as "150 mg, two tablets" rather than "300 mg," which may lead to administration of only 1 tablet of nirmatrelvir
- Confusing blister pack instructions for patients

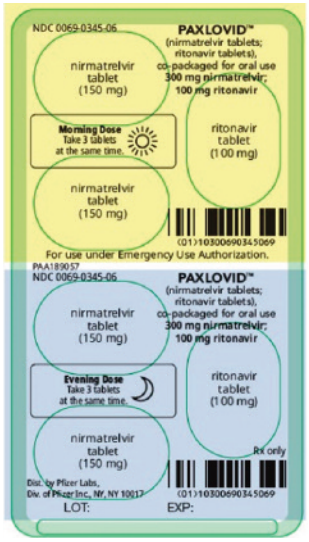

Figure 1. For patients with normal renal function or mild renal impairment, each Paxlovid carton contains 5 daily-dose blister packages with 2 tablets of nirmatrelvir 150 mg (300 mg total) and 1 tablet of ritonavir 100 mg for each morning and evening dose (30 tablets in total).

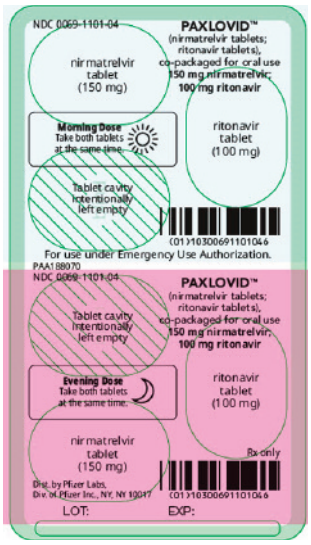

Figure 2. For patients with moderate renal impairment, each Paxlovid carton contains 5 daily-dose blister packages with 1 tablet of nirmatrelvir 150 mg and 1 tablet of ritonavir 100 mg for each morning and evening dose. One blister for the morning and evening dose is intentionally left empty (20 tablets in total).

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not scanning but firing alerts because the barcode information was not in the pharmacy computer system. To overcome this issue, they manually added these products and barcodes into the dispensing software to ensure barcode scanning would function correctly. However, at times when the barcode was not in the pharmacy system, some staff would override the barcode scanning alert if they did not have time to enter the medication barcode information into the dispensing software to allow for accurate barcode scanning. In this case, the Jakafi barcode information had already been added to the software and was scannable; the pharmacist assumed that it had not yet been added to the pharmacy system when the system fired the alert.

Before new products are added to your inventory and available for dispensing, establish a process to test the product's barcode to make sure it will scan properly using your pharmacy software and barcode scanning hardware. Update the pharmacy system as necessary with any missing product barcode information. When staff engage in barcode scanning workarounds, uncover the system-based reasons for the workarounds so they can be remedied. Coach the pharmacy staff involved to raise awareness of the risk associated with the behavior and encourage safer behavioral choices in the future. Work with staff to identify and fix any system barriers that may lead to overriding barcode scanning. Identify an individual or team to track and review data from the pharmacy and barcode scanning system, including the percent of medications with an unreadable barcode, scanning compliance rates, and overridden or acknowledged alerts. Use this data to identify and address any barriers to using the technology safely and effectively.

To help identify dispensing errors, at the point-of-sale review the pharmacy labels and content of each prescription container with the patient to check that the medication is correct and what is expected—even if this requires opening the bag. For specialty pharmacies, mail order pharmacies, and community pharmacies that ship or deliver medications to the patient's home, advise the patient (verbally and in

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SAFE PRACTICE RECOMMENDATIONS: To prevent dosing errors with Paxlovid, consider the following recommendations:

Increase awareness. Educate practitioners about the availability of the reduced-dose blister package for patients with moderate renal impairment. Remind practitioners to avoid prescribing and dispensing Paxlovid for patients with severe renal impairment.

Check EHR and prescribing system configuration. Check your EHR or prescribing system to see how the dose and tablet strength fields are displayed, and make the required alterations to ensure it is intuitive for the prescriber to select 2 of the 150 mg nirmatrelvir tablets to make up a 300 mg dose. On drop-down menus, it is safest to list the strength of Paxlovid as a 300 mg and 100 mg dose pack, or, for moderate renal impairment, a 150 mg and 100 mg dose pack (as stated on the cartons).

Clinical decision support. If possible, provide dose guidance for Paxlovid in prescribing systems, such as providing an order sentence with the required reduced dosing for patients with moderate renal impairment.

Check and confirm renal function. Confirm the patient's renal function before prescribing or dispensing Paxlovid. (See the FDA *Paxlovid Patient Eligibility Screening Checklist Tool for Prescribers* to support clinical decision making and to screen for significant drug interactions: www.ismp.org/ext/921.) If possible, prescribers should document on prescriptions the patient's most recent eGFR and date. Pharmacists without access to the patient's medical record will need to contact the prescriber if this information is not included.

Avoid communicating the dose by tablet or blister color. Do not refer to the tablets as pink (nirmatrelvir) and white (ritonavir), or by any other colors, or by the color of the blister package, as this can cause the patient to misunderstand which medications to take.

Educate patients. Mark Paxlovid prescriptions for mandatory patient education, and explore ways to use technology to prompt mandatory patient education when the prescription is picked up. Show patients how the medication is labeled on the blister pack, and teach them about the two different medications that they will be taking twice a day. Encourage them to remove each tablet just prior to taking the dose and not ahead of time (e.g., transferring them to a medication box). Use the teach-back method, making sure that patients can demonstrate how they will take the morning and evening doses. Also provide patients with the *Fact Sheet for Patients, Parents, and Caregivers* (www.ismp.org/ext/939).

Recommendations for the manufacturer. To differentiate the two packages, Pfizer should consider adding a banner on the renal dosing cartons to specify that this package configuration is for patients with moderate renal impairment. Also, Pfizer should provide patient education tools, such as laminated cards, for each package type.

Additional risk of age-related mix-ups now that our youngest patients are eligible for COVID-19 vaccines

PROBLEM: With the expanded emergency use authorization (EUA) for patients as young as 6 months old, there are now three different age groups, not just two, that are eligible for the Pfizer-BioNTech and Moderna coronavirus disease 2019 (COVID-19) vaccinations (www.ismp.org/ext/934). Similar to the mix-ups that occurred between the Pfizer-BioNTech vaccines for children 5 through 11 years old and for individuals 12 years and older (www.ismp.org/node/28619), it is predictable that we will see mix-ups between these three age groups with both the Pfizer-BioNTech and the Moderna vaccines. In the past, some individuals 12 years and older received the Pfizer-BioNTech vaccine formulation and dose intended for children 5 to 11 years old, resulting in underdoses. Or children who were 5 to 11 years old received the formulation and dose intended for individuals 12 years

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writing) to open their prescription container or sealed manufacturer package to verify the medication prior to taking it. If the medication does not look right, they should contact the pharmacy.

Different concentrations of oral liquid baclofen. FLEQSUVY (baclofen) oral suspension (25 mg/5 mL [5 mg/mL]) is a new formulation of the skeletal muscle relaxant used to treat spasticity from multiple sclerosis and may also be used for patients with spinal cord injuries and other diseases. OZOBAX is another brand of baclofen oral solution that was available before Fleqsuvy. But Ozobax comes in a different strength, 5 mg/5 mL (1 mg/mL), than Fleqsuvy, 25 mg/5 mL (5 mg/mL). The Ozobax label lists the concentration as "5 mg/5 mL," which could be confused with the 5 mg/mL strength of Fleqsuvy, although Fleqsuvy is primarily labeled 25 mg/5 mL. Prior to the availability of both commercial products, ISMP had received several reports related to confusion between various compounded baclofen concentrations. If a patient receives an under- or overdose due to a concentration error, either inadequate treatment and withdrawal syndrome, or baclofen toxicity could result. Both the American Society of Health-System Pharmacists (www.ismp.org/ext/922) and the Michigan Pediatric Safety Collaboration (www.mipedscompounds.org) recommend a concentration of 5 mg/mL for compounded baclofen oral liquid prescriptions.

Electronic prescribing and pharmacy computer systems should be configured to list the concentration of the available product (i.e., 25 mg/5 mL [5 mg/mL] or 5 mg/5 mL [1 mg/mL]). Consider applying auxiliary labels to the medication bottles to warn against confusion. Staff may also circle product concentrations on the container labels to draw attention to them. Practitioners should be made aware of the potential for error due to the different concentrations on the market, with attention given during the medication reconciliation process to ensure accurate doses are documented, prescribed, and dispensed. Doses should be prescribed in mg, and practitioners should clarify and discuss doses based on the mg dose. Use the teach-back method to educate patients and/or caregivers about the concentration,

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and older, resulting in overdoses. Similar errors could happen with the new vaccines for our youngest patients.

Moderna Vaccine

The Moderna EUA vaccine (**Table 1**) comes as a two-dose series administered 1 month apart to individuals 6 months through 17 years. Previously, the vaccine had been authorized for use in adults 18 years and older. The vaccine was also authorized to provide a third primary series dose at least 4 weeks following the second dose for individuals 6 months and older who have certain kinds of immunocompromise.

Table 1. Moderna COVID-19 Vaccine Formulations (www.ismp.org/ext/935)

Age group	6 months through 5 years for two-dose *primary series* 0.25 mL (25 mcg)	6 years through 11 years for two-dose *primary series* 0.5 mL (50 mcg)	6 years through 11 years for two-dose *primary series* 0.5 mL (50 mcg) *18 years and older *booster dose* 0.5 mL (50 mcg)	12 years and older for two-dose *primary series* 0.5 mL (100 mcg) *18 years and older *booster dose* 0.25 mL (50 mcg)
Vial cap color	Dark blue	Dark blue	Dark blue	Red
Vial label border color	Magenta	Teal†	Purple	Light blue

†May not be available currently

Pfizer-BioNTech Vaccine

The Pfizer-BioNTech EUA vaccine (**Table 2**) comes as a three-dose series for children 6 months through 4 years in which the initial two doses are administered 3 weeks apart, followed by a third dose administered at least 8 weeks after the second dose. Previously, the vaccine had been authorized for use in individuals 5 years and older as a two-dose primary series. The vaccine was also authorized to provide a third primary series dose at least 4 weeks following the second dose for individuals 5 years and older who have certain kinds of immunocompromise.

Table 2. Pfizer-BioNTech COVID-19 Vaccine Formulations (www.ismp.org/ext/937)

Age group	6 months through 4 years for three-dose *primary series* 0.2 mL (3 mcg)	5 years through 11 years for two-dose *primary series* and *booster dose* 0.2 mL (10 mcg)	12 years and older for two-dose *primary series* and *booster dose* 0.3 mL (30 mcg)
Vial cap and label border color	Maroon	Orange	Purple or gray

According to the *Fact Sheet*, vaccine vial labels for the youngest age group may state "Age 2y to < 5y" or "Age 6m to < 5y," and carton labels may state "For age 2 years to < 5 years" or "For age 6 months to < 5 years." These vaccines can be used for children 6 months through 4 years old (www.ismp.org/ext/936). However, locations that receive these vials may find it confusing and mistakenly believe the formulation labeled "2y to < 5y" cannot be used for children younger than 2 years. Also, we do not recommend using the "<" or ">" signs, which are sometimes confused to mean the opposite.

Children who will turn from 4 years to 5 years old between any doses in the Pfizer-BioNTech's COVID-19 vaccine primary series may adhere to either of the following dosing schedules:

- Two-dose primary series (10 mcg) with the 5 through 11 years vaccine
- Three-dose primary series with the vaccine authorized for use in children 6 months through 4 years of age (3 mcg); the second or third dose may be with the vaccine for ages 6 months through 4 years **or** with the vaccine for 5 years through 11 years of age.

Safe Practice Recommendations: Consider the following recommendations, paying particular attention to these confusing issues:

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the corresponding volumetric dose, and how to measure each dose with an oral syringe.

Mix-ups between fluticasone formulations. Over the past few years, ISMP has received multiple reports of mix-ups involving fluticasone propionate aerosol metered-dose inhalers (**FLOVENT HFA**) and fluticasone propionate nasal spray (**FLONASE**). Fluticasone aerosol metered-dose inhalers are indicated for the maintenance treatment of asthma as prophylactic therapy while fluticasone nasal spray is used to temporarily relieve the symptoms of hay fever or other upper respiratory allergies. If a patient incorrectly receives the nasal spray instead of the metered-dose inhaler, they could miss doses of their asthma maintenance therapy and experience asthma exacerbations.

In most reports, fluticasone metered-dose inhalers were ordered but the nasal spray product was dispensed. For some of these events, directions for the metered-dose inhaler (e.g., inhale two puffs into the lungs twice a day) were printed on the pharmacy label that was affixed to the nasal spray product. In another case, the metered-dose inhaler was correctly selected and dispensed but the pharmacy label contained instructions to use the inhaler via the nasal route of administration. These errors appear to have happened when the pharmacy technician or pharmacist selected the wrong formulation during order entry or when retrieving the wrong product from the shelf. One report indicated that the product's barcode was not scanned during production, missing an opportunity to catch the error.

Explore ways to differentiate these products in computer systems such as modifying the product names to include wording such as *metered-dose inhaler* or *nasal spray*. Barcode scanning technology is widely available today and all pharmacies should be consistently using barcode scanning technology during production. Finally, provide patient counseling, open the bag of dispensed medications, and have the patient review the medications. In fact, one of the reports indicated that the error was caught while counseling the patient as they were expecting a metered-dose inhaler instead of a nasal spray.

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- The Moderna vaccines for children 6 months through 5 years, and for 6 years through 11 years, both have a dark blue cap and an age range that starts with the number "6" on the label. Also, the vial with the purple border only lists the indication for a booster dose, but it is currently the only vaccine intended for use in children 6 years through 11 years.
- The Pfizer-BioNTech vaccines for children 6 months through 4 years and for 5 years through 11 years both require a volume of 0.2 mL for each dose (3 mcg and 10 mcg, respectively) but are provided in different concentrations. Also, the primary series for children 6 months through 4 years requires three doses, while the primary series for children 5 years through 11 years requires only two doses.

Segregate storage. In refrigerators and freezers, store the vaccine formulations apart from one another in separate plastic bins properly labeled with the corresponding age group. Differentiate the bin labels with colors that align with the vial label color, keeping in mind that purple may be the label color for both the Pfizer-BioNTech vaccine for patients 12 years and older, and the Moderna vaccine for children 6 years through 11 years.

Verify identity, age, and vaccine(s) requested. When checking in a patient who is scheduled to receive a vaccine(s), ask the parent, caregiver, or patient to provide at least two patient identifiers—their full name and date of birth. Verify the patient's actual age with the patient, parent, or caregiver, and be sure to ask which vaccine(s), including the brand, they have requested. Repeat this process immediately prior to vaccination.

Verify the vaccine history. Prior to vaccine preparation, check the patient's vaccine card, the patient's medical record, and the immunization information system to confirm which COVID-19 vaccines have been administered previously and when.

Label syringes. Clearly label all syringes. To facilitate labeling, print labels for each patient or provide practitioners who prepare the vaccines with strips of preprinted labels that differentiate the formulations and doses. Please help us learn how your practice site is implementing this recommendation by participating in our short 5-question survey at: www.ismp.org/ext/944. We are accepting responses through **July 29, 2022**.

Employ barcode technology. During preparation and administration, use barcode scanning to confirm the correct vaccine.

Vaccinate one patient at a time. Only bring the intended and labeled vaccine syringe(s) for one patient into the vaccination area. Vaccinate one patient at a time.

Engage the patient. Involve the parent, caregiver, or patient in verifying the vaccine, formulation, and dose by reading the label to confirm the correct vaccine.

Document the vaccine(s). Document the lot number and date of manufacture prior to vaccine administration, and document administration afterwards in the patient's profile, on vaccination records, and via state or other immunization information systems.

Report vaccine errors. Report vaccine errors internally as well as to the Vaccine Adverse Event Reporting System (https://vaers.hhs.gov), which is mandatory for COVID-19 vaccines available under an EUA. ISMP also asks providers to report vaccine errors to the ***ISMP National Vaccine Errors Reporting Program*** (www.ismp.org/report-medication-error).

Additional resources. For details on immunization schedules, please review the Centers for Disease Control and Prevention (CDC) resource, *COVID-19 Vaccine Interim Immunization Schedule for 6 Months of Age and Older* (www.ismp.org/ext/938). Also, Immunize.org has compiled a tool (www.ismp.org/ext/933) that organizes information about US COVID-19 vaccines and provides links to dosing guidance, *Fact Sheets*, package inserts, storage and handling, and preparation and administration. This resource is updated at least monthly.

Special Announcements

New resource for specialty pharmacies

ISMP and our affiliate, ECRI, have launched a new online membership for specialty pharmacies. Membership provides actionable guidance and practical strategies for safe medication management, including resources that can be used to help meet accreditation standards, stay informed about new technologies and best practices, and create safety improvements to reduce the risk of medication errors. Membership can include access to specialty drug proactive risk assessments, user group access, and the ISMP community/ambulatory care newsletter. To learn more, please complete the form at: www.ismp.org/node/31616.

Virtual MSI workshops

Don't miss the opportunity to register for one of our unique 2-day, virtual ***ISMP Medication Safety Intensive (MSI)*** workshops being offered in 2022. Our next workshop is scheduled for **August 4 & 5, 2022**. For more dates in 2022 and to register, visit: www.ismp.org/node/127.

Apply for a Just Culture scholarship

The Just Culture Company, in cooperation with ISMP, will award three ***Judy Smetzer Just Culture Champion Scholarships*** annually to honor Judy Smetzer, BSN, RN, FISMP, a retired ISMP vice president. Applications for next year's scholarships are due by **July 31, 2022**. For details and to apply, visit: www.ismp.org/node/30840.

ISMP Medication *Safety Alert!* Community/Ambulatory Care (ISSN 1550-6290)

Report medication and vaccine errors to ISMP: Call 1-800-FAIL-SAF(E), or visit www.ismp.org/report-medication-error. ISMP guarantees the confidentiality of information received and respects the reporters' wishes regarding the level of detail included in publications.

DOs and DON'Ts for submitting an ISMP Cheers Award Nomination

Do you know an individual or an organization/group collaborative that you want to nominate for an **ISMP Cheers Award**? Here are some helpful tips to make sure your nomination meets the criteria. **Nominations that are incomplete or do not meet the criteria outlined below will not be considered.**

DO

Nominate an Individual or Organization/Group Collaborative that:

- Clearly identifies a high-risk, error-prone medication safety initiative
- Demonstrates successful implementation of the initiative
- Provides measurable outcomes
- Utilizes innovative, proactive medication error-reduction strategies based on ISMP's philosophy and recommendations in ISMP newsletters, ISMP ***Action Agendas***, ISMP guidelines, and other ISMP resources
- Participates in medication safety committees, teams, and/or does advocacy work
- Will share the initiative with others (at no cost)
- Exemplifies a commitment to the promotion of medication safety

Complete the nomination form:

- Ensure all fields are filled in accurately and completely.
- Provide your information as the submitter.
- Provide information about the nominee (self nominations are accepted).
- Provide a paragraph summarizing why you believe this nominee should receive an award.
  - In your own words, please highlight the project/nominee description, the impact of the initiative, and/or the nominee's commitment to medication safety (five to ten sentences).
- After submitting the nomination, upload documentation to support the nomination (e.g., a full description of the nomination and safety initiative, slides, data tables, diagrams, figures, meeting minutes, pamphlets, curriculum vitae [CV]).
- Additional forms and information required for **Organizations**:
  - An Interdisciplinary Commitment Declaration
  - Proof of accreditation by an appropriate professional body (e.g., The Joint Commission)
  - Proof of executive leadership commitment by completing a Leadership Declaration

Submit your nomination, along with supporting documents and forms, by September 9, 2022.

DON'T

Don't submit a nomination that does not clearly identify a high-risk, error-prone medication safety initiative.

Don't submit only one or two sentences about the nominee without supporting documentation.

Don't forget to complete all the information on the nomination form before submitting.

Don't enter pages of information into the summary text box (summarize the project/nominee in only five to ten sentences).

Don't forget to upload a full description of the nomination, medication safety initiative, and additional documentation to support your nomination after completing the initial form (after you submit the nomination).

Don't forget to submit all your information by September 9, 2022.

For a list of past **ISMP Cheers Award** winners, click here.