RECIPE FOR SUCCESS

A Pocket Guide to Writing Prescriptions For the New and Not-so-New Practitioner

By Joe Goldstein, R.Ph.

©Joe Goldstein, R.Ph, 2016

ACKNOWLEDGEMENTS

This is my first attempt at writing and publishing a book or manual, and I must thank several people for their encouragement, editorial assistance, and putting up with me.

Edward Hoffer, M.D.
Donald Stevens, M.D.
Victor Ferzoco, M.D.
Steven Margolis, M.D.
Emilio Mastrodomenico, R.Ph.
Sarah Marasigan, R.Ph., Pharm.D.
Stephen Cohn

And of course my wife Ellen, and our family, whose reactions have ranged from incredulity to ennui and elation.

CONTENTS

Introduction		1
I.	What is a Prescription	5
II.	They're not always sick	13
III.	The Components of a Prescription	20
IV.	Sign the Prescription	45
V.	The Process	52
VI.	You Are Unique	59
VII.	A Word About Fraud	65
VIII.	Almost done	68
IX.	Appendix	73
About the Author		77

Whether you are an MD, DO, OD, DMD, DDS, DVM, NP, PA or anyone else with the authority to issue prescriptions, this book has something for you. Filled with practical applications, concrete examples and more than just a few anecdotes, *Recipe for Success* will give you a look into prescription-writing with a focus on patient safety, while saving you and them (and the pharmacist) valuable time.

ISBN: 978-1-62249-340-1

Published by
The Educational Publisher Inc.
Biblio Publishing
BiblioPublishing.com

Introduction

This work is about safe and effective prescription-writing. It's about giving the best care possible in the best and most efficient manner. It's about getting the right drug to the right patient at the right dose and at the right time, with correct and understandable directions for use. It's about time management and minimizing disruptions to your (and my) work day as the result of sloppy practices or perceived capabilities (but actual limitations) of existing systems. It's about reducing barriers to your patients receiving the most appropriate treatment in the timeliest manner. It's about you, the prescriber, working in concert with the pharmacist to realize positive therapeutic outcomes for our mutual patients.

As dedicated, concerned health professionals we should be working toward our common goal: improving the health of our patients. With the application of some of the suggestions, concepts and principles contained herein we should be able to reach that goal with minimal efforts or changes to our routines, and in a timely fashion, all the while demonstrating our respect for the value of our patients' time. I do not pretend to know the best treatment choice for every patient or for every medical condition. That's your job. You will have the

advantage, and many of you already have it, of seeing the results of your treatments in your patients.

Patients will usually stay with one provider for the duration of a course of treatment. It is too common for them to receive their medications from multiple pharmacies. Pharmacists are taught to understand the actions of the drugs and their effects on the body. You more often actually see the results of the drugs as they work, both good and bad. But being a good clinician does not necessarily mean you will be a good prescriber. You will find several of the prescription examples and prescribing principles or ideas repeated here, perhaps multiple times. It is not an indication of my advancing age. It simply means I want to drive these points home, because they are important.

Why another book on prescription-writing? There are dozens of such references available as hard copy and soft-bound tomes, as well as on line, and I have purposely declined to reference them, or any other published work. I think *Recipe for Success* is unique, being from the perspective of the pharmacist. I'm not placing blame, except on the technology that we all use. This technology has not yet had all the "bugs" removed, but we all rely on it daily for very critical functions. Sometimes our reliance on our devices makes us lazy and complacent. I

have always advocated using our technology to supplement our own knowledge and capabilities, not to replace them.

All renderings of prescriptions that appear here are based on real prescriptions, as are my descriptions of other prescriptions and/or events. These prescriptions were never filled as written. The prescribers were contacted and new prescriptions were issued or modifications were made. Seriously, I don't have a good enough imagination to make up some of these. Almost all prescriptions were received over several years in Worcester, a large city in central Massachusetts, but my experience is not unique. Worcester is the home of two large medical centers and a medical school. The city houses many drug treatment programs, family planning clinics, and a publicly-funded general and multi-specialty clinic that treats a very large indigent population as well as thousands of undocumented residents from outside the United States. Several colleges and universities call Worcester home. It is a diverse city in age, economics and ethnicity of its population.

Regardless of where they practice, every pharmacist and prescriber faces challenges similar to these. These examples are just the tip of the iceberg. Reproducing all the offending prescriptions would require reams of paper. The original source documents were shredded. While the drugs and prescribing habits

encountered in my practice may not always mirror those of other geographical areas, the principles are the same.

Everyone makes mistakes. It is not my intention to belittle anyone or any profession. It is my plan to demonstrate to you many of the problems we encounter at the pharmacy level, and to suggest some ways to alleviate those problems so that by implementing them, the impact on your time and your practice is minimal and patient care is enhanced. Pharmacists are not better equipped to handle issues than are physicians, nurses, medical assistants, or receptionists. All are uniquely qualified to do their jobs. All serve a vital role in the health care chain. And it is likely that prescribers will have far less contact with pharmacists than will their staff members. Perhaps making others aware of some of the pharmacy work barriers will bring a few more insights to the whole process of health care delivery. All the examples here are presented for your information, education and even entertainment. But please don't ever forget this is a serious business in which we are engaged.

What is a Prescription?

Simply stated, a prescription is an order by a licensed professional who has been granted their authority by the jurisdiction in which they practice. That authority must be earned by demonstrating a certain level of competence, clinical skills, and some level of judgment. The order they execute may be for drugs, supplies, devices, tests or other diagnostic or therapeutic activities.

Prescriptive authority is not absolute. The right and privilege to issue an order are usually limited by statute, policy or even by common sense. Prescribers should stay within their "comfort zone". But sometimes the lines blur. Clearly a cardiologist may prescribe antibiotics and anti-inflammatory agents. Can (or should) a podiatrist prescribe diet pills to an obese

woman to relieve pressure on her arches? How about a dentist who prescribes a vaginal antifungal cream to his female patient who suffers from a yeast infection as a result of the penicillin he has prescribed? Should an anesthesiologist prescribe glaucoma drops for her mother who is visiting? States often caution licensees about prescribing to family members and go on to define the limits of prescribing medication for family as well as for self. A true doctor-patient relationship should always exist. The prescriber should be fully prepared and able to manage any complications (think about the dentist with the vaginal cream!). And what of the pharmacist's corresponding responsibility (spelled L-I-A-B-I-L-I-T-Y)? Are you visiting from another state? If you don't have a license to practice here then you cannot write a prescription here. Are you licensed in multiple states, but have different prescriptive authority in each state? Make sure you're following the rules and regulations of the state you're in.

A prescription is a recipe that defines the desired ingredient(s), quantity, directions for use, duration of use, and allowed refills. Until the latter one-third of the twentieth century, practicing pharmacy consisted largely of mixing ingredients in a specific manner, order and ratio with defined quantities. These "recipes" often presented challenges to pharmacists.

While the prescriber's handwriting was usually more legible than that found today, the formulas to be followed could be intricate. The list of ingredients could be as many as eight to ten. The pharmacist had to know if the ingredients were chemically compatible and safe if mixed together. Ingredients often had to be added in specific order and in exacting ratios. Tablets, capsules and suppositories, as well as other dosage forms (pills, troches, pastilles, tablet triturates) were frequently custom-made by hand.

In the pharmacy school curricula of old, prescription compounding was the emphasis (the "art" of pharmacy). During the mid-1970's the focus began to shift more to the actions and effects of the drugs. We studied how they work, and how the body responds to them (the "science" of the profession).

But the schools were reluctant to let go of what was clearly a diminishing part of the profession. I still remember the formula for a compound we made weekly in our pharmacy practice lab. Called "Lahey Mixture #3", the formula was to mix 2 Grams of sodium phenobarbital, 20 ml of belladonna tincture, and add peppermint water to a total volume of 240 ml. If we added the belladonna too quickly, or to too little peppermint water, we formed an insoluble precipitate. Using phenobarbital alkaloid instead of the sodium salt yielded

similar results. Most of us caught on. Some didn't.

While only a small portion of the classroom time is allotted to compounding today, compounding pharmacies serve their patients' needs, and these skills can still be developed. One skill that is being sacrificed is that of using a two-pan torsion balance in favor of a simpler digital single pan scale. While the latter is easier to use and unrivaled for accuracy, the profession is losing one of its iconic symbols. (Figure A1).

A1. An older double pan Torsion balance, circa 1950.

The extemporaneous compounding of ingredients has given way to the dispensing of pre-made dosage forms prepared hundreds or even thousands of miles away. It is common for

today's medicines to originate in Puerto Rico, Israel, the British Isles, or India. In fact, having our drugs made elsewhere sometimes creates the problem, as some patients refuse to use drugs that are made in certain countries.

The days of "secundem artem" (according to the art) have given way to pure pharmaceutical science. Gone are the phone calls such as: "This is Dr. McDonough and give Mrs. Jones eight ounces of my cough mixture, one teaspoon every eight hours. One refill. Goodbye". Dr. McDonough's cough syrup was made up of preset ratios of six ingredients, two of which were potent opioid narcotics. Modern pharmacy is better in many ways, but several challenges still remain, as you will soon see.

Compounding pharmacies exist, and have carved out their niche. They play an integral part in health care, providing important medications that may not be commercially available for both human as well as animal use.

Please do not take your prescriptive authority lightly. With it come tremendous responsibility, pressure and temptation. You will be asked by friends, relatives, colleagues and even people you have just met to write prescriptions for them. I caution you to make it your policy to never issue a drug order for anyone with whom you do not have a professional patient-provider relationship.

Make your prescriptions legal. Review the Federal requirements under the Controlled Substance Act of 1970. Be familiar with the requirements of the state and municipality in which you practice. While many mirror Federal law, some impose additional restrictions. For example, the Massachusetts controlled substance laws, Chapter 94(c) of the General Laws of Massachusetts, allow out-of-state Schedule II opioid prescriptions to be filled in that state only if they are issued in contiguous states or in Maine, whereas other non-opioid Schedule II drugs may be issued from any state or U.S. territory. Such prescriptions from Massachusetts may be filled within 30 days of the date written, but those from outside the Bay State are good for only five days. And all prescriptions for controlled substances from any prescriber we do not know must be verified.

Early in my practice in Worcester I was approached by a young woman who handed me a prescription for Percocet® (oxycodone / acetaminophen), a narcotic analgesic combination. The woman was well-dressed, had a pleasant appearance, and was polite and well-spoken. She stated the prescription was for her sister, who had just had surgery (in another town about 50 miles away), and had come to stay with her for a few days while she recovered. She also asked for some Colace®

(docusate) capsules, a stool softener often used to counter the constipating effects of narcotics. I phoned the doctor's office and the prescription was immediately confirmed, just a little too quickly. I obtained another phone number for the doctor, reached him at another office, and found I was the fourth pharmacist to call him that morning about a prescription. It seemed that someone had got some of his old prescription blanks and set up a dedicated phone line that went directly to a home so any inquiries could be verified. This was the most elaborate scheme I had encountered. The woman must have seen me on the phone and become suspicious, because she never returned. Everything was turned over to law enforcement officers.

I tell the pharmacy students I mentor that their first obligation as a pharmacist is to the jurisdiction which licenses them. Second comes the patient, although it could be argued that the pharmacist is second. Third is the employing unit (a legal term). I submit to you that the order of obligation for the prescribing practitioner is the same: state, patient, self, employer.