Medication Use Policy

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CHAPTER ONE

INTRODUCTION

1-1. Purpose: To provide a unifying medication management process for U.S. military forces within United States Central Command (USCENTCOM) area of responsibility (AOR), consistent with Theater, Service Specific, and / or Unit Level processes for safe medication use.

1-2. Intent: Safe Medication Use within the USCENTCOM AOR is based on tenets found within Federal Law, Theater and Service specific guidance, and Joint Commission Medication Management guidelines. The intent of this policy is not to re-state or supplant guidance from those documents, but to address gaps or special topics of interest that pertain to the expeditionary military medical environment.

1-3. Scope: This policy applies to all U.S. military forces within USCENTCOM AOR responsible for acquisition, storage, and use of medications.

1-4. References: See Appendix A

1-5. Background: Laws and regulations for the practice of pharmacy exist to assure the safety and appropriateness of medication therapies provided to patients. Command emphasis and support for the proper management, control, accountability, and documentation of medication related services will foster the safe and efficient use of medications and reduce the likelihood of abuse or diversion.

1-6. Policy: Proper management of medical operations is of Command interest throughout the USCENTCOM AOR. Implementation and execution of the requirements identified in this policy will be assessed through USCENTCOM Theater Pharmacist Site Visits and through Command Inspections on a periodic or as needed basis.

CHAPTER TWO

PHARMACY ADMINISTRATION

2-1 Security and Access to Pharmacy and Medication Storage Areas

a. Medication storage in austere and expeditionary environments requires different standards than those in established and enduring facilities. Mission and limited resources drive risk mitigation strategies that balance capabilities with functional diversion prevention. This policy outlines baseline requirements that are derived from the Drug Enforcement Agency (DEA), Department of Defense (DoD) and service specific regulations and are applicable to all medication storage areas including diazepam injections issued as part of Medical Chemical Defense Materiel/ Biological Warfare/Chemical Warfare (MCDM/BWCW).

b. Ship-based medication management will be guided by existing Navy policy/regulations.

c. The Commander in charge of the medication storage area bears ultimate responsibility for ensuring this policy is aggressively adhered to and appropriate security is maintained. Deviations from this policy may be necessary based on mission and resources. Deviations must be systematically identified, addressed and formally documented to ensure appropriate risk mitigation.

d. All personnel charged with the responsibility to procure, store, prescribe, issue and/or dispense medication will be appropriately vetted by their Commander. These personnel will be briefed on their responsibility and documented in the following ways:

(1) Individuals granted unaccompanied access to medication storage areas will be listed on an access roster. The access roster will be posted in the storage area, updated as personnel change and signed/dated by the Commander. A separate access roster will be maintained for unaccompanied controlled substance access if it differs from the general medication storage area. The controlled substance access roster will also reflect who is given access to the electronic inventory system (e.g., Theater Medical Information Program Composite Health Care System (TC2), if used).

(2) A key control roster will be maintained for the medication storage area and the controlled substance safe. Individuals who have been issued physical keys and/or door/vault combinations will be listed. This is to be updated as personnel and/or locks change.

(3) Individuals granted authority to order and receive medications will be annotated on Department of the Army Form (DA Form) 1687 (Delegation of Authority for Ordering and Receiving Medical Supplies). The incoming unit will generate new DA Form 1687s after every transition of authority. These forms are then used by United States Army Medical Materiel Center-Southwest Asia (USAMMC-SWA) and United States Army Medical Materiel Center-Europe (USAMMCE) to register accounts and to ensure only approved individuals can order medications. If the DA Form 1687 expires then the customer account will be locked until it is updated.

(4) The commander overseeing the local pharmaceuticals will appoint and oversee the Disinterested Inventory Officer (DIO) as prescribed in Appendix B.

e. All medication storage areas will have the following physical security measures:

(1) It is the Commander's responsibility to ensure the medication storage area provides adequate security as mission, resources and medication storage size will be unique to each facility. While the physical design may differ, non-controlled medications will always be stored in a locked container or within a locked area that prevents unauthorized access. Locked areas will be of a substantial quality to prevent simple circumvention.

(2) Signs will be posted outside secured areas stating, "Off Limits To Unauthorized Personnel."

(3) All medication storage areas/containers will remain locked unless occupied or guarded.

(4) Combination locks will be changed when the staff changes. A Standard Form (SF) 700 will be utilized to record individuals that have the code to the lock. The form will be attached to the locked area and the tear off portion (2A) will be sealed an in envelope and stored in a secured lockbox.

(5) Locks with physical keys will be changed if keys are lost or if diversion occurs.

(6) An SF 702 will be posted outside of the safe and outside the locked area. Opening, closing and security checks will be documented on the SF 702.

(7) Security checks will be conducted on an irregular basis during non-duty hours to avoid establishing a predictable pattern. Security checks will be conducted at least every 4 hours during non-duty hours.

(8) Controlled substances will be secured behind at least two locks. The storage container for controlled substances will be one of the following:

(a) A General Services Administration (GSA)-approved field safe

(b) A vault room consisting of solid concrete or steel walls (or bars), solid ceiling and floors and a solid vault style door. The structure is built in such a way to significantly deter and delay penetration with hand tools.

(c) If mission does not allow for use of an approved safe or vault, the Commander may choose a similar container that is secured to prevent both unauthorized access and theft of the entire container. The Commander will document the diversion mitigation strategy.

(9) In-transit security of controlled substances must be such that the spirit and intent of this policy are not violated and that controlled substances are protected from unauthorized possession, use, and theft. Controlled items must be removed from assemblages and packed and shipped separately. An inventory will be conducted at the issuing location with the issuer and at the receiving location with the receiver.

(10) Satellite medication storage in patient care areas (e.g., clinic/ward stock) should only be stored in patient care areas with limited access, preferably in a room with a lockable door. Housekeeping personnel will be escorted by medical unit personnel with access to medication storage areas. Access should be restricted to those individuals authorized to prepare, administer, or dispense medications.

f. All transactions of controlled substances will produce a paper trail, from procurement to final disposition. The chain of custody is represented by the signatures on these documents and they must be saved in order to be audited during the monthly DIO inventory. These documents include (but are not limited to):

(1) Procurement: Shipping receipt from medical logistics (MEDLOG), DA 3161 or similar

(2) Storage record: Log or register showing all local transactions

(3) Final disposition: Department of Defense (DD) 1289 or similar prescription, DA 3161 or similar transfer record, waste documented on storage record.

(4) Printout from electronic inventory system (e.g., TC2, Pyxis, Theater Enterprise-Wide Logistics System (TEWLS))

g. The following inventories of controlled substances are to be conducted and annotated on the storage log or register.

(1) Weekly 100% inventory of all controlled substances

(2) Daily inventory of controlled substances that were issued/dispensed or received since last inventory (movement inventory)

(3) Shift change inventory for controlled substances held outside of the pharmacy storage area. To be conducted with incoming and outgoing staff member.

(4) 100% inventory when responsible parties switch out.

(5) Monthly Disinterested Officer Inventory (DIO) per Appendix B

h. Intrusion Detection Systems (IDS) and/or video surveillance systems are not required, but recommended where large amounts of medication are stored (e.g., logistic units, role 3). Implementation of these devices will be used in addition to (not in replacement of) the base requirements of this policy. Use of these systems requires establishment of local policy that defines usage and maintenance requirements to ensure they provide the intended level of security and appropriate response. The Commander is responsible for the oversight of these systems.

i. Theft, loss or mismanagement of medications will be reported through the chain of command.

2-2 Inspection and Disposition of Prescription Files and Records

a. Inspection. Prescriptions and related records will be subject to inspection by higher echelon medical commanders and the USCENTCOM Theater Pharmacist at all times.

b. Maintenance. All hard copy prescriptions and orders filled by the pharmacy will be placed in files established and maintained in the pharmacy. Prescriptions will be numbered serially and initialed by the individual who checked them. Three or more series of numbers will be used; one series for Schedule II controlled substances, alcohol, and alcoholic liquors; one series for Schedules III, IV, and V controlled substances; and one series for all others. A corresponding file will be established for each series of numbers. Pharmacies using TC2 or any other theater-approved pharmacy system will develop a suitable alternative method to electronically number, check, and file prescriptions.

c. Stock Records. The pharmacy will maintain a record of receipts and expenditures of all controlled substances and locally controlled medications. A separate record will be maintained on the appropriate service specific form for each dosage form in which the item is supplied except where an equivalent locally approved automated accounting record is used (TC2).

d. Disposition. Prescription files, controlled substance records, and other records (e.g. pre-pack logs) related to medication use will be retained **in theater** for a minimum of two years.

2-3 USCENTCOM Pharmacist Staff Assistance Visits

a. USCENTCOM Theater Pharmacist Staff Assistance Visits (SAVs)) provide the MTF Pharmacy personnel an opportunity to demonstrate compliance with regulatory guidance, theater policy, standards of practice in pharmacy operations and medication management. Areas of emphasis include: controlled substance inventory, control and accountability, record and file management, quality control, supply, physical security, training, medication dispensing and administration.

b. Upon entry into theater, units will conduct a self-assessment of their medication management strategy by utilizing the USCENTCOM Theater Pharmacist's SAV checklist (Appendix C; or contact USCENTCOM Theater Pharmacist). Incoming pharmacist/unit will also conduct a 100% inventory of controlled substances on hand and a thorough review on non-controlled substances to review stock levels and expiration dates.

c. Pharmacy SAVs will occur once per unit/personnel rotation at each theater medication storage area. The Theater Pharmacist (FWD) will attempt to visit all medication storage locations personally, but other theater pharmacists may be trained to conduct SAVs as necessary.

(1) Coordination between the Theater Pharmacist (FWD), the unit commander and Service Component Command will occur to ensure appropriate support and synchronization.

(2) SAVs conducted by pharmacy personnel other than the Theater Pharmacist (FWD) will be sent to the Theater Pharmacist (FWD) for review.

(3) If an in-person SAV is not feasible for a rotation, a virtual SAV can be conducted.

d. USCENTCOM Theater Pharmacist visits are not an intended part of a formal Organizational Inspection Program (OIP). A military treatment facility (MTF) Commander or Surgeon Cell may request a transition to an OIP. This may occur via USCENTCOM Theater Pharmacist recommendation or observation of unsafe patient care.

e. USCENTCOM Theater Pharmacist visits are official visits and are to be coordinated in advance. The USCENTCOM Theater Pharmacist will provide a copy of the visit documents (relevant references, service specific guidance, checklist, and results template) a minimum of 14 days in advance of arrival.

f. An abbreviated checklist for use in veterinary clinics and Role 1 Facilities is found in Appendix D.

g. The summary of the visit will be provided to:

(1) The Commander of the unit visited

(2) The USARCENT Command Pharmacist at Shaw AFB for review and archiving in MS Teams

(3) Surgeon Directorate (Clinical Operations) of Service Component

h. Trends will be monitored for action and reported through the USCENTCOM Pharmacy and Therapeutics (PTC) Committee. Completed SAV memos will be stored on MS Teams in the USCENTCOM Theater Pharmacy Team page.

CHAPTER THREE

RULES FOR ELIGIBILITY

3-1. PHARMACY RULES FOR CARE ELIGIBILITY.

a. Provision of pharmacy services within USCENTCOM AOR is determined by interpretation of the current USCENTCOM Medical Rules of Eligibility (MEDROE) and through categorization on the current USCENTCOM Modification (MOD) Criteria TABS A-D (see reference c).

b. Using the construct above, “Emergency Care” is considered analogous to “Acute Care”, and “Routine Care” refers to “Chronic” or “Maintenance Medications”. Therefore, “Emergency” prescriptions are those with a maximum of thirty days supply of medications. “Routine” prescriptions contain greater than 30 days’ supply of medication (typically 90 days of supply).

c. Current USCENTCOM MOD Criteria TABS A-D provides specific criteria for medical conditions (i.e. non-deployable, waiver required) and prescription medications (i.e. non – deployable, waiver required, or non USCENTCOM formulary) for any personnel that may enter USCENTCOM AOR (Service members, General Schedule (GS) Civilians, or Contract staff).

d. Due to the exhaustive listing of medical conditions and medications, Pharmacy personnel using this policy are urged to consult both the current USCENTCOM MEDROE and US CENTCOM MOD Criteria to determine prescription care eligibility.

e. Based on above criteria, Pharmacy staff providing “emergency” care may process up to 30 days of medication supply for a prescription. For Prescriptions for “routine” care (i.e. greater than 30 days), mail order pharmacy must be used. Refill prescriptions are not authorized.

f. Examples of mail order include Express Scripts / Deployment Prescription Program (DPP) for active-duty personnel and may be found at https://tricare.mil/dpp.

DoD Civilians and contract employee personnel are covered by a mail order pharmacy under their defined contract service or insurance plan contracted to provide services to their personnel.

g. Unit level Commanders, Role 1-3 MTF Commanders, or the Chief, Pharmacy service in their discretion may allow limited exceptions to these Medical or Pharmacy Rules of Care for Eligibility.

CHAPTER FOUR

MEDICATION SELECTION AND PROCUREMENT

4-1. USCENTCOM FORMULARY SYSTEM.

a. The USCENTCOM Theater Pharmacist is the Formulary Manager through the USCENTCOM Pharmacy and Therapeutics Committee (PTC). The process and policies are found in the current edition of the USCENTCOM PTC Charter.

b. MTF Pharmacies staffed by a pharmacist are required to maintain a local PTC in order to critically assess MTF medication management in their facility.

c. Units in the USCENTCOM AOR may only order and stock medications that are listed on the USCENTCOM Formulary. USCENTCOM MEDLOG and the USCENTCOM Theater Pharmacist will monitor ordering to ensure formulary adherence and appropriate controlled substance utilization. See section 4-2 for information on non-formulary medication procurement.

4-2. FORMULARY MODIFICATION AND NON – STANDARD REQUESTS.

a. Any clinical or pharmacy staff within USCENTCOM may request to add a medication to the USCENTCOM formulary. This requires completion of a New Drug Request (NDR) (APPENDIX G; available from USCENTCOM Theater Pharmacist). Route the completed NDR Form to the USCENTCOM Theater Pharmacist. The USCENTCOM Theater Pharmacist will analyze the request and forward it to the USAMMCE-SWA Pharmacist to determine procurable status. If procurable, the requestor will present their reasoning for adding the item to the formulary to the PTC during the next scheduled meeting.

b. Alternatively, one-time requests for non – formulary medications based on urgent or compelling patient need may be processed through the Non Formulary Drug Request (NFDR) form (Appendix G), also available through USAMMC – SWA (see reference s). Similar to the NDR process above, route thru the USCENTCOM Theater Pharmacist.

c. For either NDR or NFDR requests, to facilitate requests in the least possible time, it is recommended to coordinate requests via Outlook email to both the SWA and

USCENTCOM Theater Pharmacist, who will immediately acknowledge receipt and request status.

4-3. EMERGENCY OR EXPEDITED MEDICATION REQUESTS.

a. USAMMC – SWA can process Urgent / Emergent Priority Designator (PD) 02 requests (to expedite requests prior to normal delivery timeline) on request. Follow process as described in USAMMC- SWA SOP (see reference s).

b. USAMMC – SWA can process Life or Death (Life, Limb, or Eyesight) PD 03 requests that will ship within 24 hours if on hand. This process requires the coordination of assets across military branches and involves the entire theater, including Air Force determination if an airframe can be diverted, and if the item(s) can be hand carried to the individual in need. A Designator 03 is taken very seriously; abuse or violation of the system is discouraged. To accomplish, follow process as described in USAMMC- SWA SOP (see reference s).

c. Regardless of PD type (02 or 03), requesting sites are urged to immediately notify USAMMC-SWA Pharmacist or Customer Support telephonically, during business or non-business hours to expedite the request.

4-4. BLOOD DERIVATIVES. The procurement, storage, control and distribution of manufactured processed blood derivatives (such as albumin, gamma globulin, Rho (D) immune globulin, intravenous (IV) immune globulins and coagulation factors) are managed by the pharmacy. Other blood products (whole blood, plasma, etc.) are managed directly by the Blood Bank.

4-5. RADIOGRAPHIC CONTRAST MEDIA AND RADIOPHARMACEUTICALS. The Department of Radiology at Role 3 facilities is responsible for the procurement, storage, control, distribution and administration of radiographic contrast media and radiopharmaceuticals.

4-6. ANTI – VENIN PROGRAM (SNAKE / SCORPION / BLACK WIDOW SPIDER).

a. Anti-venin agents are managed via U.S. Central Command SOP Anti-Venin Use, current edition (see reference d). Anti-venins are Investigational agents (Non -- FDA approved) and require special handling and procedures.

4-7. SELF-CARE OVER THE COUNTER (OTC) MEDICATION PROGRAMS.

a. The Chief, Pharmacy service, or Role 1 – 3 Commander may in their discretion operate an Over the Counter (OTC) self-care medication program. OTC products contain limited quantities of medications, and are sealed in original manufacturer packaging, for retail sale in the United States. Such OTC packaging typically contains the full name of the medication, directions for use, and warnings.

b. Items dispensed are limited to OTC medications and packaging that comply with Federal law. On patient request, non-credentialed providers may issue OTC self-care medications, although their ability to counsel patients may be limited. Unstructured medication hand out programs are not authorized.

c. The USCENTCOM Theater OTC / Self Care Medication list is found in Appendix E.

d. To the maximum extent possible, items dispensed will be documented in the patient's Electronic Health Record (EHR) in either AHLTA –T or TC2.

e. Patients who utilize OTC Self Care Programs and do not experience symptom relief or clinical improvement within 1 to 2 days are encouraged to make a provider appointment to address their health needs.

CHAPTER FIVE

MEDICATION SUPPLY AND STORAGE

5-1. REQUISITION AND RECEIPTS.

a. Stock Levels. It is the responsibility of the Chief and Noncommissioned Officer in Charge (NCOIC), Pharmacy Service, to ensure adequate quantities of appropriate medications are maintained in the pharmacy. As a general rule, stock levels should be set at a 45-90 day supply, reflecting order arrival times from USAMMC – SWA. Reorder points will be established based upon mission, usage levels and therapeutic treatment options.

b. Receiving. Medical Supply is responsible for delivering ordered pharmacy medical supplies. Each item received will be inventoried for the correct receipt quantity and expiration date as listed on the Materiel Release Order (MRO) form. The original MRO will be given to Medical Logistics and a copy will be maintained in the Pharmacy for reconciliation. The status of items not received will be “traced” with the USAMMC-SWA customer service division using a Report of Discrepancy (ROD).

5-2. MEDICATION STORAGE WITHIN THE PHARMACY

a. Medication will be stored in a neat and orderly manner that provides the proper security, temperature, moisture control, and protection from light. Medications will be stored IAW the manufacturer’s guidance.

b. Medication will be arranged alphabetically by generic name and separated in sections (topicals, tablets and capsules, rectals, oral liquids, injectables, otics, ophthalmics, bulk, refrigerated, hazardous, and flammable items) in a manner that it can be found by the members of the pharmacy staff.

c. Non – Formulary medications, if any, are to be stocked in a stand-alone section with a minimal or zero re-order point set for inventory control / re-order points.

d. Hazardous Medications (or Hazardous items) are physically segregated from other stocks and identified as such.

(1) A list of such items may be determined from the Centers for Disease Control and Prevention (CDC) / National Institute for Occupational Safety and Health (NIOSH) list found at https://www.cdc.gov/niosh/review/peer/isi/hazdrug2018-pr.html

(2) Examples of control mechanisms include use of personal protective equipment (PPE), additional cleaning of preparation / storage area after dispensing, separate counting trays or preparation areas, and controlled disposal of supplies use to prepare, dispense or administer the hazardous medication.

(3) Each unit with Hazardous Medications either on hand, contemplated for use, or within their scope of practice will create and prominently publish an annual "HAZARDOUS MEDICATION" SOP and drug list, including risk mitigation strategies and other pertinent info from the Safety Data Sheet (SDS).

e. Flammable (i.e. combustible) items are to be physically segregated from other stocks and identified as such.

(1) Alcohols, ethers, and other volatile (i.e. anesthetic gases) are typical examples of flammable items. Refer to manufacturer packaging, the chemical nature of the agent, SDS, and other information sources to determine the potential combustibility.

(2) Flammable materials shall be stored in GSA or Occupational Safety and Health Administration (OSHA) approved flammable material or storage containers and removed from excessive heat sources.

5-3. CYTOTOXIC MEDICATIONS.

a. As a general rule, there are no cytotoxic agents on the USCENTCOM formulary, with the exception of methotrexate injection. Methotrexate should be segregated from other medications and only ordered by providers experienced in treating and monitoring patients receiving methotrexate.

b. All precautions should be taken to ensure the safe storage, preparation, administration, and disposal of supplies surrounding the use of methotrexate injection.

Preparation is limited to those Role 2 - 3 units with the ability to safely utilize this medication in the deployed environment (i.e. with biological safety cabinet or other containment device to protect staff / patients from risk).

5-4. EMERGENCY MEDICATIONS.

a. Emergency medications and supplies that are used during Mass Casualty (MASCAL), Cardiopulmonary Resuscitation (CPR), Malignant Hyperthermia (MH), or other will be readily available in patient care areas and stored in crash carts.

b. To the greatest extent possible, emergency medications will be provided in ready-to-use, unit dose forms. They will also be age-specific when possible. Crash cart drugs will be stored in trays and crash carts will be locked at all times which allows the pharmacy and clinic/ward staff to determine if the tray has been opened or tampered with. Unit level SOP will determine whether to use a tray exchange or cart exchange system for re-supply of emergency medications.

c. As a general rule, crash cart locks are maintained in the pharmacy as a controlled item. The patient care area in which the crash cart is located is responsible for the security of the cart. Crash carts will be sealed or locked and secured in a locked room when not in use or under constant surveillance.

d. To the greatest extent possible, crash cart contents will be standardized. A list of item contents should be prominently displayed with location, quantity, expiration date, and date / time / legible signature of person completing the most recent check for cart integrity and expiration date.

e. Unit level guidance will determine the frequency of emergency medication cart checks. The pharmacy will maintain a numbered crash cart lock issue log, with columns for date / time / issue location / and legible name / signature of personnel the lock is issued to.

5-5. RETURNS AND DESTRUCTION OF DRUGS, BIOLOGICALS AND REAGENTS.

a. There is no reverse distribution system in theater for overstocked and/or expired medications. There are rare cases where overstocked medications can be cross leveled to other MTFs in theater. Contact the Theater Pharmacist to assist with potential movement.

b. Medications dispensed to patients, contaminated, or administered to patients either on the ward or through the clinic will be disposed of. Medications will not be thrown away in trash containers.

c. Hazardous and flammable medications will be separated, labeled as flammable or hazardous, and coordinated with Medical Supply for destruction.

d. Expired Controlled Substances will be separated from other stocks and destroyed in the presence of an assigned witness. Controlled substances must be destroyed within one month of being identified for destruction. (See 5-5 g in accordance with 5-5 f.)

e. Active controlled substances separated for destruction must be secured and inventoried the same as viable controlled substances, regardless of expiration date.

f. A record of such destruction, signed by the two witnesses, is filed in the controlled substances file as authority for dropping the items from the records of the accounts. The monthly Disinterested Officer can serve as a witness.

g. Proper destruction includes any locally approved process that renders the substance non-retrievable or inert while also limiting the potential for the substance to contaminate water and food sources. Examples include: incineration, controlled detonation, commercial destruction product (Rx Destroyer) or mixing with an unappealing substance.

5-6. TEMPERATURE SENSITIVE MEDICAL PRODUCTS (TSMP).

a. All activities receiving shipments containing TSMP should receive and refrigerate (2-8°C) the contents in a timely manner to reduce product exposure and prevent product loss. All shipments containing TSMP originating from USAMMC-SWA or USAMMC-E will be packed according to protocols in insulated shipping boxes with refrigerated and frozen gel and will contain a digital temperature recording device (“Temp-Tale” or equivalent) to validate temperature stability and timeframe.

b. On receipt of shipment, the receiving unit will follow USAMMC-SWA instructions for proper processing of the “Temp-Tale” or equivalent monitoring equipment.

c. Refrigerators containing pharmaceuticals will use a digital thermometer or built-in integrated monitoring system. All refrigerated materiel will be stored at the manufacturer’s recommended storage temperatures, normally between 2 – 8 degrees Celsius. Refrigerator/freezer units will have their temperatures physically checked and documented twice daily (i.e. once in the AM and once in the PM) if 24 hour remote monitoring systems exist. If no remote system, then temperature checks should occur every six hours.

(1) Temperature ranges outside 2-8 degree Celsius shall immediately be resolved and the refrigerator monitored for temperature fluctuations. All actions must be documented on the temperature log. Refrigerators/Freezers will be clearly marked showing appropriate temperature range, what type of unit it is (refrigerator/freezer), and state if the temperature scale used is reading as Fahrenheit or Celsius.

(2) In the event a medication refrigerator or freezer fails to maintain a suitable temperature range, medications must be moved to an alternate TSMP sites for safeguarding and medical maintenance contacted.

(3) Sequester products found outside of the required temperature range. Contact the Theater Pharmacist or the Pharmacist at USAMMC-SWA before using or destroying the medication.

5-7. PRODUCT EXPIRATION DATES.

f. All personnel who store, prepare, dispense, or administer medications are responsible for monitoring medication expiration dates. Stocks shall be rotated to ensure the earliest expired drug is used first.

a. Suspended or expired stocks must be physically segregated from other stocks and identified as suspended or expired. Use signage stating “EXPIRED MEDICATION AREA – DO NOT USE”.

b. Multi-Dose Vials (MDV) of injectable medications (i.e. multi-dose vials) will have the expiration date recorded on the vial upon first use. The expiration date will be calculated as 28 days after the vial is opened unless otherwise specified by the manufacturer. If there is any question as to when a MDV was first used, it will be discarded and replaced with a new one. All MDVs must be discarded immediately if the integrity of the container appears compromised or the quality of the product is questionable. After first use, opened vials will be labeled with the expiration date (e.g. “Expires MM / DD / YYYY”). All multiple dose vials may be discarded prior to the 28 day expiration or manufacture’s expiration date if its sooner or the integrity of the container appears compromised.

c. MDVs of vaccines may be used until the vials’ expiration date or sooner when specified by the manufacturer provided that appropriate storage conditions are followed.

d. Single-dose containers of injectable medications (i.e. single-dose vials) will be discarded immediately after one use.

e. All other medications unless expired or contaminated may be used to the MM / YYYY displayed on the original manufacturer packaging.

f. Defense Health Agency (DHA) Shelf-Life Extension Program (SLEP):

(1) SLEP is a formal program developed in collaboration with the US Food and Drug Administration (FDA) to avoid replacement costs for potency-dated pharmaceuticals in pre-positioned stockpiles.

(2) Only certain federally stockpiled medical materiel (i.e., Medical Countermeasures (MCM)) can have their expiration date officially extended through the program.

(3) SLEP requests and inquiries should be directed to the Theater Pharmacist

and the USAMMC-SWA help desk.

g. Local use of medications beyond the manufacturer's expiration date:

(1) Manufacturer shortages and MEDLOG procurement delays in theater may lead to difficulties in replacing expiring medications.

(2) **The use of medications beyond the expiration date is an emergency action when other clinically appropriate courses of action are unavailable. This action must be approved through the Theater Pharmacist.**

(3) The pharmacist or clinic OIC should contact the Theater Pharmacist and USAMMC-SWA Pharmacist as soon as the potential/pending shortage is discovered to explore all other alternative sources of supply and comparable products. **Do not wait until the medication expires.**

(4) The risks of keeping the expired medication in stock for possible use will be weighed against the risks of not having that medication available at all.

(a) Tetracycline is the only medication that is known to be nephrotoxic when expired.
(b) The amount of the active ingredient still in the active chemical form can degrade over time. Exposure to extremes in temperature, light, humidity, and air may increase degradation.
(c) Loss of sterility

(5) Requests for extensions of medications beyond their expiration date will be recorded in Memorandum for Record (MFR) Format (Appendix H) and routed through the local MTF Pharmacy (if applicable) and to the USCENTCOM Pharmacy Consultant for review.

h. Some single-dose vials may be used as multi-dose vials for veterinary medicine purposes only. Storage, beyond-use-dating and general quality control of these vials must be done in accordance with veterinary medical guidance.

CHAPTER SIX

MEDICATION MANAGEMENT

6-1. HIGH ALERT MEDICATIONS

a. High-alert or high-risk medications are agents with a historical pattern or statistical probability of being involved in high percentage of medication errors and / or sentinel events.

b. Examples of mechanisms whereby high alert medications may harm patients include intravenous route, intra-thecal route, narrow therapeutic index, and permanent (not time limited) effect.

c. Various Pharmacy industry organizations, to include Institute of Safe Medication Practices (ISMP) and the United States Pharmacopoeia (USP), annually publish High Alert Medication (HA-M) lists. An example of such a list in an acute care hospital setting may be found at: https://www.ismp.org/recommendations/high-alert-medications-acute-list

d. All Pharmacy organizations or medication storage areas are directed to create, publish, and prominently display a "High Alert -- Medication" (HA – M) list. This list should be site specific, and reflect medications stocked, scope of practice, and potential risk points or catastrophic pathways that may impact patients.

e. An essential component of a HA – M list are risk mitigation strategies, ranging from staff education, TALLman lettering, time out / second check procedures, special storage, and auxiliary caution stickers, among others.

f. An example of a High Alert Medication list is found in Appendix F, however all USCENTCOM Pharmacies / or medication storage areas are strongly urged to create their own unique listing.

6-2. SOUND ALIKE – LOOK ALIKE DRUG (SA-LA D) LISTS.

a. SA-LA Drugs involve medication names or packaging with similar spelling, phonetic sounding name, labelling or packaging, or therapeutic use and have historical patterns or statistical probability of being involved in higher percentage of medication errors and / or sentinel events.

b. Various Pharmacy industry organizations, such as the Institute of Safe Medication Practices (ISMP), annually publishes a list of SA-LA Drugs incorporated with paired drug names. An example of such a list in an acute care hospital setting may be found at: https://www.ismp.org/recommendations/confused-drug-names-list

c. All Pharmacy organizations or medication storage areas are directed to create, publish, and prominently display a SA – LA Drug list. This list should be site specific, and reflect medications stocked, scope of practice, and potential risk points or catastrophic pathways that may impact patients.

d. An essential component of a SA-LA Drug list are risk mitigation strategies, ranging from staff education, TALLman lettering, time out / second check procedures, special storage, and auxiliary caution stickers, among other mitigation strategies.

e. An example of an SA-LA Drug list is found in Appendix G, however all USCENTCOM Pharmacies or medication storage areas are strongly urged to create their own unique listing.

6-3. MEDICATION MATERIEL QUALITY CONTROL (MMQC) MESSAGES.

a. Medical Materiel Quality Control (MMQC) messages, issued by the US Army Medical Materiel Agency (USAMMA), contain information of Recalls, Patient Safety Updates, Shelf Life Extension Program (SLEP), destruction instructions, and other significant quality control activities.

b. ALL USCENTCOM Pharmacies or locations with medication storage areas will register to receive these messages via the following link:
https://a01.usamma.amedd.army.mil/mmip/MMQC/Subscription/Add

c. MMQC messages pertain to medical equipment, medical / surgical supply, pharmaceuticals, vaccines, and other topics of interest.

d. MMQC messages range from actionable (response required, check inventory) to informational messages.

e. Medication Materiel, Pharmaceutical, or Vaccine Recall:

(1) USAMMC-SWA routinely monitors MMQC messages to determine if affected materiel processed through its distribution pipeline en route to Role 1 – Role 3 customers throughout the USCENTCOM AOR. This messaging occurs via the Defense Medical Logistics Standard Support (DMLSS) communication portal to customers with DoD Account Activity Codes (DoDAAC) on the Authorized Activity List (AAL).

(2) Upon notification by either USAMMC-SWA or MMQC message, pharmacy personnel will check their stocks and other wards/clinics for the recalled medication or materiel.

(3) Reports of medications affected will be reported to USAMMC-SWA customer support cell, the USAMMC-SWA Pharmacist, and the USCENTCOM Theater Pharmacist.

(4) This report will include Product Name, NDC, Lot, Expiration, and Quantity affected.

(5) Affected sites are responsible for re-ordering replacement product (SWA will not automatically replace product).

(6) Based on recall instructions, SWA will send disposal instructions – i.e. return through normal PRMP channel, or in unusual circumstances to SWA directly.

6-4. DESIGNATION OF "LOCALLY CONTROLLED" ITEMS.

a. The unit Commander or the Chief, Pharmacy Services may, in their discretion, recommend designation of any Class VIII medication materiel as "locally controlled" items to prevent potential abuse or diversion. The USCENTCOM Theater Pharmacist can assist with this process as needed.

b. Methods of accountability may range from storage within pharmacy service to similar protocols as if Schedule II or Schedule III–V controlled substances.

c. The Chief, Pharmacy Services, along with the Chief Medical Officer (CMO), will develop written protocols to ensure safe medication use.

6-5. ANTIMICROBIAL STEWARDSHIP PROGRAMS (ASP).

a. USCENTCOM CCOP 02: Infection Prevention and Control Policy in a Deployed Setting provides guidance and requirements on establishing ASPs at MTFs.

CHAPTER SEVEN

PATIENT SAFETY

7-1. USCENTCOM PATIENT SAFETY PROGRAM.

a. USCENTCOM Regulation 40 –1 Healthcare Operations describes requirements and delineates roles and responsibilities for the US CENTCOM Patient Safety program.

7-2. MONITORING MEDICATION EFFECTS ON PATIENTS.

a. Medication monitoring, including evaluation of the effects of medications on patients, is a multidisciplinary process. Input from the patient and/or family members (if present), as well as other members of the multidisciplinary team are used to assess, maintain, and improve the patient's medication regimen. The patient's medication regime is determined by the goals of the patient's treatment plan through observation and assessment by the healthcare team and in consideration of the needs and desires of the patient.

7-3. MEDICATION ERROR RISK REDUCTION PROGRAM.

a. Definition: Medication errors are preventable event cascades that lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.

b. Every effort should be made to proactively identify areas of medication error risks and develop performance improvement initiatives to address the gaps. Additionally, each medication error should be investigated to assess and address causes through patient safety reporting as described in USCENTCOM Regulation 40 –1.

7-4. ADVERSE DRUG REACTION (ADR) MANAGEMENT PROGRAM

a. Definition: A response to a medicinal product that is noxious and unintended, and that occurs at doses normally used in humans for the prophylaxis, diagnosis, or treatment of disease or for the restoration, correction, or modification of physiological or psychological function. ADRS should be reported through patient safety reporting as described in USCENTCOM Regulation 40 –1.

b. Side Effects: ADR's that are unwanted or undesirable extensions of pharmacologic activity, within a normal therapeutic dosage range, that do not meet criteria above, are considered side effects. Side effects are managed therapeutically for patient care, but not reportable as an ADR.

7-5. VACCINE ADVERSE EVENT REPORTING SYSTEM (VAERS).

a. Adverse events attributable to Vaccines are mandatory report items to the VAERS system and to the patient safety reporting system. To complete online form use the following link: https://vaers.hhs.gov/index.html

7-6. DO NOT USE ABBREVIATION LIST

a. Joint Commission Standards for Acute Care Hospital organizations contain a robust list of DO NOT USE abbreviations during the medication use process.

b. At minimum, the following website displays the currently approved list.
https://www.jointcommission.org/facts_about_do_not_use_list/

c. Various pharmacy associations have created supplemental DO NOT USE abbreviation lists, to include the Institute for Safe Medication Practices (ISMP). The following link displays the ISMP "List of Error Prone Abbreviations"
https://www.ismp.org/recommendations/error-prone-abbreviations-list

d. Role 1 – Role 3 facilities and medication storage areas are strongly urged, based on their scope of practice and medication storage, to create and prominently post a DO NOT USE abbreviation list.

7-7. MEDICATION CONSULT PROCESS.

a. The Health Experts onLine Portal (HELP) is an asynchronous remote consult system. Clinical specialists in all therapeutic disciplines are available. Follow https://help.nmcp.med.navy.mil/path/user/Login.jsp Allow 24 hours for initial account access.

CHAPTER EIGHT
PRESCRIBING POLICIES

8-1. INDIVIDUALS AUTHORIZED TO WRITE PRESCRIPTIONS.

a. USCENTCOM Regulation 40 -1 delineates the credentialing and privileging process within USCENTCOM AOR.

b. The following credentialed providers are authorized to prescribe medications: Military and civilian (if any) physicians, dentists, and veterinarians.

(1) Veterinarians may only prescribe within their normal scope of practice for animals.

(2) Dentists may only prescribe for the treatment of dental diseases or logical extensions of dental disease.

(3) Nurse Practitioners, Independent Duty Corpsmen, Physical Therapists, Physician Assistants and Pharmacists may prescribe within their scope of practice as determined by their privileging and unit level, Service specific, or Theater level guidance.

c. Medics, respiratory technicians, and other non – credentialed providers, IAW with Theater, Service specific, unit level guidance, scope of practice or clinical practice guidelines, may, when authorized in writing by their commander, dispense or administer limited medications, under the professional oversight of a credentialed provider. The credentialed provider must review the care provided within 24 hours or as soon as practical, and ensure the appropriate documentation occurs in the medical record.

d. Individuals with prescribing privileges are not authorized to prescribe controlled substances for themselves or family members.

8-2. PROVIDER SIGNATURE AUTHORIZATION.

a. As a general rule, computer physician order entry (CPOE) via HALO or TC2 (CHCS) is the standard for theater healthcare. If an electronic system is not used, then prescription or medication order must bear the original signature of an individual authorized to write prescriptions.

b. A system of record containing executed DD Form 577 Signature Card (or a local approved signature form) will be maintained by the pharmacy to validate the signature of providers authorized by the Commander to prescribe or enter medication orders.

c. Prescriptions or medication orders presented without a current or valid DD 577 Signature Card on file for a provider will not be honored. Verbal orders or requests for one time exception will not be honored. There are no exceptions to this policy.

d. The pharmacy will honor bulk drug orders for medication other than controlled substances when signed by a designated representative of the unit/section authorized. The name and signature of each designee must be provided to the pharmacy in advance.

e. Orders for controlled substances will be signed by individuals authorized to write prescriptions for these items or by a registered nurse when needed for stock in a patient care area. The name and signature of each designee authorized to receive controlled substances must be provided to the pharmacy in advance by the unit leadership in memorandum format.

8-3. PRESCRIPTION BLANKS.

a. DD Form 1289 (DoD prescription), Navy Medicine (NAVMED) 671-/6 (Poly Prescription), or Air Force (AF) Form 781 (Multiple Item Prescription) can be used. All authorized prescriptions must be signed by an authorized prescriber. Local alternatives may be developed and approved by the Commander.

b. Controlled substances should be written on a DD Form 1289 only with no more than one controlled substance per form. The signature and printed name of the designee receiving the controlled substance from the pharmacy must be printed legibly on the back of the DD 1289 form.

c. Only one prescription item, regardless of drug schedule and non-schedule classification, will be allowed on each DD Form 1289. NAVMED 671-/6 (Poly Prescription), or AF Form 781 (Multiple Item Prescription) may contain multiple non – controlled prescriptions or medication orders.

8-4. PRESCRIPTION WRITING.

a. Prescriptions will be dated and signed on the day written and bear the full name and Social Security Number (SSN) or Department of Defense Identification (DoD ID) of the patient. When patients present more than one prescription for other than controlled substances, the full name must be on all prescriptions with the addition of the SSN or DoD ID on at least one prescription.

b. Prescribers will record their DEA number on all prescriptions for controlled substances. The prescriber will place his or her signature, rank, branch of service and stamped, typed, or printed name on each prescription.

c. Prescriptions written for children will include the child's weight in kilograms.

d. In the event that a multiple prescription is presented to the pharmacy and they do not stock all the medication ordered, the pharmacy will make a copy of the prescription (if feasible) for the pharmacy files. The original prescription will be annotated specifying which items were filled and returned to the patient. An original prescription must be on file for controlled substances.

e. Dispensing Quantity limits: Dispensing Quantity limits are IAW Theater guidance. See current USCENTCOM MOD criteria (reference c).

CHAPTER NINE

DISPENSING POLICIES AND OUTPATIENT PHARMACY OPERATIONS

9-1. PRESCRIPTION DISPENSING

a. The Chief, Pharmacy service and the Commander are responsible for ensuring adherence with unit and theater level guidance.

b. The Pharmacy service is the only approved source of supply for medications in fixed Role 3 facilities.

c. Medications to be dispensed to US personnel will not be procured from foreign sources. Foreign medications are not FDA approved, are considered investigational new drugs (IND) and would require significant review. Antivenom products are currently the only approved medications procured from foreign sources.

d. Patients will only be issued medications from established USCENTCOM MEDLOG sources. Medications dispensed to patients cannot be reused or redistributed.

e. The patient or designee must sign for receipt of dispensed controlled substances in the outpatient setting.

f. Verbal (direct or telephone) Medication Orders should be kept to a minimum and transmitted in emergent situations only (i.e. mass casualty). All verbal orders will use the read back method and be followed-up with written documentation using one of the methods above by an authorized prescriber within 24 hours.

g. All prescriptions will be dispensed in approved containers to maintain potency. Acceptable containers include child-resistant prescription bottles. As a theater level

expedient, plastic zip-lock prescription dispensing bags with label windows are acceptable for limited use / days of supply, although these are not compliant with the Poison Prevention Control Act of 1970.

9-2. MEDICATION LABELING.

a. Individual Outpatient Prescriptions: A label will be prepared for each prescription dispensed to individuals and will be securely affixed to the container prior to dispensing. The information on the label will be consistent with Federal Law.

(1) Supplemental labels will be affixed to prescription containers as dictated by the pharmacist's professional judgment and the current standard of pharmacy practice. Such labels will be used to warn individuals of potential interactions or side effects, special handling or storage requirements, or poison considerations.

(2) At a minimum, the label on all medications will contain:

(a) Location and phone number of dispensing site.
(b) Patient name.
(c) Directions for use.
(d) Date of dispensing.
(e) Prescriber name.
(f) Drug name.
(g) Strength.
(h) Amount or quantity (if not apparent from the container).
(i) Expiration date.
(j) A prescription serial number (Rx number) and telephone number for the dispensing site/pharmacy.
(k) For all controlled substances the legend "CAUTION: Federal law prohibits the transfer of this drug to any person other than the person for whom it was prescribed" will be typed on the prescription label or affixed to the prescription container.

b. Ward and Clinic Issue:

(1) Labeling requirements for medications issued in bulk to wards, clinics, and other authorized agencies will include at minimum:

(a) Location and phone number of dispensing site.
(b) Patient name.
(c) Date of compounding.
(d) Name / initials / Date of manufacture.
(e) Generic Drug name(s).
(f) Strength or concentration.
(g) Amount or quantity (if not apparent from the container).
(h) Internal Control / quality control lot number
(i) Expiration date.

(j) For all controlled substances the legend "CAUTION: Federal law prohibits the transfer of this drug to any person other than the person for whom it was prescribed" will be typed on the prescription label or affixed to the prescription container.

c. Pharmacy Pre- Packaged Medications (from bulk containers or stock bottles):

(1) Will contain the medication name, strength, quantity, pre-approved directions for use, the manufacturer's name and lot number or locally assigned lot number, expiration date, and the location of the pre-pack or dispensing site. The label will also include blank lines for the patient’s name, the provider's name, the medic's name (if dispensing under protocol), and the date issued to be filled in upon dispensing.

(2) Pharmacies pre-packaging medications from bulk containers or stock bottles will retain a pre-packing log book (as a quality control measure) containing:

(a) Date of compounding.
(b) Name / initials of individual performing the compounding.
(c) Name / initials of individual performing the “double check” for accuracy.
(d) Generic Drug name(s).
(e) Manufacturer Name, Lot and Expiration Date.
(f) Strength or concentration.
(g) Amount or quantity (if not apparent from the container).
(h) Internal Control / quality control lot number
(i) Pre-Pack expiration date (typically 6 months from pre-pack date or manufacturer expiration date, whichever is soonest).
(j) Auxiliary caution stickers as appropriate.

d. Labelling requirements -- Computer Down Time:

(1) Role 1 – Role 3 pharmacies should create, IAW Unit Level or Service Specific guidelines, contingency back-up procedures to enable ongoing pharmacy operations.

(2) During periods of computer down time, the product labeling requirements for prescriptions and intravenous admixtures remain unchanged, however, the method of documentation on the label (i.e. handwriting) must be legible and complete.

9-3. SELECTION OF MEDICATION.

a. The correct medication must be selected and the proper number of doses placed in an appropriately labeled container. If the medication does not have an imprint code or identifying marks that would allow the person checking the prescription to positively identify the medication, the container from which the medication was retrieved will be placed with the prescription until a double check is completed.

b. The person who selected/retrieved the medication will initial the label in the upper left hand corner. The filled container will then be checked before dispensing. Whenever feasible, a second individual should check all prescriptions before dispensing. The DoD Tech Check Tech (T-C-T) program will be used to the maximum extent possible.

9-4. PRESCRIPTION NUMBERING AND FILING.

a. All hard copy prescription and orders filled by the pharmacy or designated medication storage area will be placed in files established and maintained in the dispensing area. Prescriptions will be numbered serially and initialed by the individual who checked them.

b. Three or more series of numbers will be used; one series for Schedule II (Note R) controlled substances, and medicinal alcohol; one series for Schedules III, IV, and V (Note Q) controlled substances; and one series for all others. A corresponding file will be established for each series of numbers. Pharmacies using TC2 or other designated computer system will develop a suitable alternative method to number, check, and file prescriptions.

9-5. EMERGENCY CONTRACEPTION

a. Levonorgestrel 0.75mg (Plan B) is to be available to female beneficiaries of reproductive age. This medication will be available on an as request basis from Role 1 – Role 3 pharmacies. Pharmacy staff are to document in the electronic medical record to the greatest extent possible.

b. Females may request Plan B on their own behalf. Similarly, males may request Plan B on behalf of a eligible female beneficiary of reproductive age, however to successfully request they should either present the CAC ID card of the female patient receiving, or front and back image or facsimile. In this circumstance, the female will be documented as the patient, and the male will be picking up the medicine (from the pharmacy).

c. Once a female patient has been issued two Plan B doses in a six month sliding period, they will be referred to a primary care physician for a contraceptive medication consultation.

9-6. LONG ACTING REVERSABLE CONTRACEPTIVES (LARC):

a. The following LARC products (Nexplanon, Paragard, and Levonorgestrel) are CENTCOM formulary approved and available for use with the following restrictions:

(1) Nexplanon: Provider must have manufacturer training certificate on how -- to safely administer.

(2) Paragard, and Levonorgestrel: Role 1 – 2 MTFs must have ultrasound on hand to ensure safe placement (per manufacturer guidelines). Role 3 MTFs typically have ultrasound device available.

b. Role 1 – 2 facilities: CENTCOM formulary restricted, and available upon provider request as NFDR for individual patient use.

c. Role 3 facilities: Available as CENTCOM / formulary stocked item(s), with the caveat that the burden for safe administration lies with Role 3 clinical staff. May only be issued pursuant to a prescription, with administration documented in the electronic medical record (i.e. not be maintained as ward / clinic stock issue item).

9-7. PATIENT COUNSELING.

a. Providers or dispensing personnel will conduct prospective drug utilization reviews and offer counseling to all patients receiving prescriptions.

b. Dispensing personnel are encouraged to provide printed patient information sheets on medications dispensed whenever deemed appropriate, available, and to supplement verbal counseling.

c. Dispensing personnel should be sufficiently versed and be able to verbally counsel patients on the use, potential side effects, and drug interactions associated with medications to be dispensed. Appropriate references should be readily available to answer questions from both patients and medical staff regarding these products.

d. Providers will document any adverse events believed to be due to the use of medications, dietary supplements, or vaccines in the patient's medical record.

e. Counseling will adhere to HIPAA and patient privacy requirements.

f. The following QR Codes can be given to and used by patients to look up information for their prescribed medications:

DailyMed
National Library of Medicine

MedlinePlus
National Library of Medicine

9-8. MEDICATIONS RETURNED BY PATIENTS.

a. Medical personnel will collect all medications brought in by patients who are admitted to a Role 1 – 3 facility. A record will be maintained by the pharmacy of all medications turned-in.

(1) If the medication is carried in stock by the Role 1 – 3 facility, the option of either discarding the medication or storing the medication until the patient is discharged. If the patient has the same medication prescribed upon discharge and the retained medication is suitable for re-issue, then it may be returned to the patient with appropriate labeling. Medications not re-issued will be turned in for destruction.

(2) If the medication is not stocked by the Role 1 – 3 facility, it will be stored until the patient is discharged. It may be returned to the patient upon discharge if approved by the attending physician.

(3) The turn-in of controlled substances will be performed with a physical count and receipt system.

(4) Any medication held for more than 14 days after the patient is discharged, or not reissued upon discharge, will be turned in for destruction.

b. Except as noted below, medications collected from inpatients and stored at the pharmacy will not be used for treatment. All medications to be administered to inpatients will originate from pharmacy stocks.

(1) Patients may be allowed to utilize their personal medications when alternative medications stocked in the pharmacy are not acceptable.

(2) Providers or pharmacy personnel must positively identify the personal medications and there must be a written order (describes medication, dose, route, and frequency) from an authorized provider. Blanket authorization is not appropriate. This information must be documented in TC2 as part of the medication profile.

9-9. ORDERING AND DISPENSING OF MEDICATIONS BY ENLISTED MEDICAL TECHNICIANS

a. For the purpose of this section, enlisted medical technicians include Navy Hospital Corpsman, Army Medics and Air Force Medical Technicians who may function semi-autonomously under the oversight of credentialed privileged providers as dictated by mission. Independent Duty Corpsmen (IDC) and Independent Duty Medical Technicians (IDMT) operate as per their service guidance.

(1) Enlisted medical technicians are assigned a medical supervisor (qualified credentialed provider-physician, physician assistant or certified nurse practitioner).

These medical supervisors must certify enlisted medical technicians in the proper use of algorithm-directed medication prescribing.

(2) Medical supervisors ensure they perform within their scope of practice.

(3) They may operate beyond the immediate supervision of a medical provider.

b. NATO or Coalition enlisted medical technicians from other country members' armed forces shall operate IAW guidelines from their own command surgeon or armed forces regulatory guidance.

c. Any medication issued/administered by the enlisted medical technicians is dispensed under the license of the supervising provider. This must follow completion of training and certification in accordance with (IAW) theater and unit level guidelines. Certification includes training on the indications, contraindications, adverse reactions, dosing, and monitoring parameters for a pre-approved list of medications.

d. Medications should be pre-packaged as units sufficient to treat a Soldier, labeled for use, and double-checked by a competent second source (i.e. Practitioner, pharmacy technician or other medic) prior to dispensing.

(1) If the pre-pack method is not utilized, enlisted medical technicians can dispense out of a stock bottle provided they are furnished with pre-printed labels. With either method, the medication name, strength, quantity, pre-approved directions for use, the manufacturer's name and lot number or locally assigned lot number, expiration date, and the location of the pre-pack or dispensing site should be recorded.

(2) The label will also include blank lines for the patient's name, the provider's name, the medic's name (if dispensing under protocol), and the date issued to be filled in upon dispensing.

(3) Records of all medications issued under these provisions will be completed using one of the following methods: DA 5181-R, SF 600, AHLTA encounter, Field Medical Card (FMC), or DD 1289 (DoD) Prescription Form and make available for provider's counter-signature and entry into the patient's medical record. The medic should have the patient or witness's sign for the medication, if feasible.

e. Enlisted medical technicians may be issued controlled analgesic medications by the supervising provider to carry and administer while on mission.

(1) The enlisted medical technician is responsible for the security of the controlled substances while on mission.

(2) Upon administering a controlled substance to a patient, the following information must be recorded on the log: date of issue, quantity issued, patient name, and the medic's signature along with the name of the authorizing provider.

(3) All controlled substances will be reconciled with the supervising provider upon completion of mission.

CHAPTER TEN

INPATIENT PHARMACY OPERATIONS

10-1. Compounded Intravenous Sterile Products.

a. Pre-made commercial products will be used to the greatest extent possible. If pharmacy compounding of sterile products must occur, it will be to the greatest extent possible IAW USP 797 / 800 standards.

b. The Department of Pharmacy is responsible for compounding and preparing all parenteral medications. Exceptions to this requirement are emergency situations, when it is not feasible to wait for a pharmacy-prepared sterile product or when treatment delays may result in patient harm. These areas include Role 1 / Role 2 facilities, and the EMT, ICU, and Anesthesia – OR within Role 3 facilities.

c. In non-emergent situations, prescriptions for sterile medications may be presented either via TC2 (CHCS – Role 3) or otherwise entered into patient's medical record and processed via Unit Level, or Service Specific order form to the pharmacy by hospital/clinic personnel. Orders are reviewed by a pharmacist, if available, upon receiving the order or within a reasonable timeframe if a pharmacist is available.

d. To minimize the risks associated with the preparation of any parenteral product outside of the pharmacy, sterile products will be prepared by the pharmacy in advance and in adequate quantities (e.g., 24-hour batch supply or enough products sent to the patient care areas to last until next due 24-hour supply) unless inadvisable due to the stability or of the admixture.

e. For Role 3 Pharmacies with Laminar air flow hoods / or Biological Safety Cabinets, the pharmacy will prepare all parenteral medications using a laminar air flow hood or a biological safety cabinet. Hoods and cabinets must be appropriately maintained and certified as required. Aseptic technique will be used to minimize the risk of product contamination. These include the following:

(1) Use a clean or sterile technique.
(2) Use techniques to assure accuracy in medication preparation.
(3) Maintain a clean and uncluttered preparation area.
(4) Separate areas of medication preparation to minimize contamination.
(5) Utilize universal safety precautions to minimize exposure to self, staff or the prepared sterile product.

(6) Check the final product for particulates, turbidity or other unexpected changes prior to dispensing any sterile product.

f. Labeling Requirements. Once sterile product preparation is complete, a label will be placed on the product. Minimum labeling requirements for sterile products include:

(1) Assigned order number.
(2) Patient's name or assigned identification number.
(3) Patient's location.
(4) Name of drug.
(5) Name of diluent(s) and the appropriate quantity/volume (unless apparent on the container).
(6) Name and amount of any other additives/drugs.
(7) Date prepared, time and infusion rate.
(8) Initials of individuals who prepared and double checked the product.
(9) Any supplemental instructions or precautions.
(10) Expiration time and date of the prepared solution.

g. Labeling IV Fluids. Labels will be placed on parenteral containers intended for intravenous infusion in an inverted position so the label will be upright while the solution is being administered. Whenever possible, labels will be placed so that a portion of the original label, which identifies the base solution, remains visible.

h. Irrigation Solutions. In the event preparations are made for irrigation rather than intravenous infusion, the label must clearly bear the warning "FOR IRRIGATION USE ONLY."

i. Verification. To reduce dispensing errors, pharmacy staff members preparing sterile product(s) shall to the greatest extent possible, consistent with staffing and acuity of care, bring all components and the original order to the pharmacist or credentialed provider to check for accuracy.

10-2. UNIT DOSE PREPARATIONS

a. Role 1 – Role 3 facilities will operate with a 24-hour supply of unit dose or bulk issue distribution system for inpatient care. All medications will be dispensed in a ready-to-administer form to reduce wastage and prevent medication errors.

b. Medications stocked on the wards or in the clinics will be in a unit dose form to the maximum extent possible. This ward stock will be identified in an approved list of medications authorized to be stored and administered outside the pharmacy by licensed practitioners with appropriate clinical privileges. These individuals are also responsible for maintaining, ordering, preparing, administering and documenting the usage of stocked medications.

c. Role 1 – 3 Pharmacies may in their discretion repackage medications that are not immediately available in unit dose packaging for inpatient use.

(1) The pharmacy will keep a record of all internally repackaged unit doses. This logbook will contain both original and repackaged information, such as manufacturer name, lot number and expiration date from the original bottle, internally assigned lot number, quantity repackaged, preparer and verifier's initials.

(2) Repackaged unit dose medication labels will contain at a minimum:

(a) Generic and / or trade name of medication.

(b) Drug strength or dose.

(c) The repackaged product's uniquely assigned internal lot number and expiration date. Note: expiration dates for re-packaged items are the lesser of 12 months or the manufacturer's original expiration date.

(d) Auxiliary labels as required to ensure safe medication use.

10-3. MEDICATION ADMINISTRATION

a. Medication administration will be by a physician, registered nurse, licensed practical, nurse, respiratory therapist, physical therapist, Independent Duty Corpsmen and or Medics consistent with their clinical privileges and scope of practice.

b. Medications should not be retrieved from medication storage areas for patient administration until the time for administration. Retrieving medications to maintain on one's person or in an unsecured area until the health care provider is prepared to administer the medication is not authorized. (i.e. maintaining medications in a lab jacket pocket, at patient bedside or in conditions not suitable for maintaining medication stability is not authorized).

c. Medications retrieved but not administered to the patient must be returned to the appropriate medication storage area or the pharmacy.

d. Patient self-administration of medications at the bedside is authorized but discouraged. Acceptable examples are limited to non – active medications such as saline nasal spray or throat lozenges.

e. Specified limitations of personnel authorized to administer inpatient medications:

(1) Physicians or Registered Nurses may administer IVPB, IV push, IM, subcutaneous, intradermal, blood and blood products, oral, sublingual, rectal and topical medication.

(2) Licensed practical/vocational nurses (LPN) may administer IV solutions with electrolytes and nutrients, IVPBs (if IV certified and located in ER, ICU, OR PACU), IM, subcutaneous, intradermal, rectal, topical, sublingual and oral medications. LPNs may not initiate the administration of blood and blood products, administer IV push medications nor may they mix IVPBs.

f. Each ward will maintain a written medication administration schedule specifying times for routine drug administration. These times may be altered based on the patient's needs, however the use of standard times is highly encouraged. The new administration time should be annotated on the medication order prior to transmission to the Inpatient Pharmacy. The following are standard Inpatient Administration Times.

(1) Daily or q24h= 1000 hours
(2) BID or q12h= 1000 and 2200 hours (Diuretics are 0600 and 1800 hours)
(3) TID or q8h= 0600, 1400, and 2200 hours
(4) QID= 1000, 1400, 1800, 2200 hours
(5) q6h= 0600, 1200, 1800, 2400 hours
(6) AC (Before Meals)= 0600, 1100, 1600 hours
(7) PC (After Meals)= 0800, 1200, 1800 hours
(8) HS (Before Bed)= 2200 hours

g. The patient's past and current drug treatments will be evaluated prior to medication administration. Treatment efficacy, impact on current functioning, and side effects will be reviewed. Allergies will be identified through an initial history interview and annotated in the patient's record, TC2 and medication order.

h. All personnel authorized to administer medications will verify there are no contraindications for administering the medication and that the medication is stable. Stability checks will be performed with visual examination of the product for particulates or discoloration and verifying expiration date.

i. If provider orders are unclear, incomplete, illegible, or may in any other way harm the patient the medication administration process should halt until the order is clarified, consistent with prevention of patient harm.

j. Medications for patient administration should be prepared and charted by the person who administers the medication. Drug name, dose, route, time given and, if indicated, the patient's reaction to the medication will be charted AFTER the medication is administered.

k. Nursing staff will notify Pharmacy if doses are missing and will provide the name of the missing medication, the number of missing doses and reason, if known. Medications will not be "borrowed" from one patient for another patient.

l. Patients have the right to refuse treatment or medication, however if this occurs provider should be notified immediately. Nursing staff will also document the patient refusal.

m. Intravenous (IV) infusions are intravenous medications and solutions administered by a pump or gravity controlled drip over a period of 15 minutes to 24 hours. They include blood products, parenteral solutions containing dextrose and/or saline, and may contain added electrolytes or medications.

n. Intravenous push (IVP) medications frequently require special instructions or trained personnel to administer them. When ordering IVP, providers must take into consideration the minimum administration requirements and monitoring capabilities of specific nursing locations. If a patient is located in a nursing location that is not able to meet the prescribed level of monitoring, the following options are available:

(1) Move the patient to a monitored area.

(2) Consider alternate routes (i.e. IV piggyback) or use a syringe pump (where available).

10-4. PARENTERAL AND ENTERAL NUTRITION.

a. The Nutritional Care Division (NCD) or (similar Service Specific clinical service area) supports orders for parenteral and enteral nutrition. This clinical service, if present, will have approved procedures and processes in place to meet these requests.

b. If there is no Nutritional Care Division (NCD) or (similar Service Specific clinical service area), or clinical dietitian support is not available to provide consultation for parenteral and enteral nutritional orders, a nutrition care consult should be initiated with the next higher or available Theater dietitian resource.

c. As a general rule, parenteral or enteral nutritional orders are not considered urgent or emergent, and can be initiated IAW Unit level SOP, after the nutritional consultation successfully occurred.

d. Patient nutritional requirements should be continually re-assessed and documented in the medical record. New orders for Nutritional Care should be created IAW Unit level SOP or approved clinical practice guidelines. For example, parenteral nutrition orders should be submitted daily as 24 hours only orders until discontinued.

e. USCENTCOM AOR Role 3 facilities stock the USCENTCOM Theater formulary approved parenteral and enteral products and solutions. There are no exceptions to this policy.

f. Service Specific guidance or Unit level SOP should address the nutrition care consult process, ordering pathways (including order form format), credentialed providers, authorized nursing wards or care areas, and personnel authorized to administer.

g. Parenteral nutrition orders shall be administered IAW clinical practice guidelines, to include use of filtration, and separate lipid administration when required.

10-5. POST-OP AND TRANSFER ORDERS.

a. When a patient undergoes surgery, transferred in or out of a post anesthesia care unit, or between nursing wards or levels of care, all medication orders are canceled and must be reordered.

10-6. HOLD or RANGE ORDERS.

a. A “Hold” medication order means to discontinue a medication for a period of time until informed by the patient’s provider to release the “hold.” Hold orders must include specific parameters, including conditions for holding and continuing the medication, or it will be discontinued.

b. A “Range” medication order means that a medication may be administered based on the patient condition or circumstance. Examples include date / time ranges (Q 4-6 hours PRN) or symptom ranges (pain level 1 – 3). However, safe medication orders cannot contain two or more ranges (Tylenol 1 – 2 tablets every 4 – 6 hours as needed for pain).

10-7. STANDARDIZED INTRAVENOUS CONCENTRATIONS.

a. To decrease variability and prevent medication errors, drug concentrations will be standardized throughout the USCENTCOM AOR. A list of these medications / drug concentrations can be found in APPENDIX I. Further, to aid safety, these will available via the USCENTCOM formulary as Ready To Use (RTU) infusion solutions to the greatest extent possible.

b. In the event a non-standard concentration is required (i.e. due to fluid restriction), providers will contact the pharmacy to coordinate the preparation of an acceptable alternative.

10-8. PATIENT-CONTROLLED ANALGESIA

a. Patient-controlled analgesia (PCA) is a method of pain relief which has proven to improve pain management, better utilize nursing resources, improve patient satisfaction, and improve pulmonary function. However, unfavorable outcomes and other adverse effects have also been associated with PCA including patient deaths.

b. In light of the risks associated with PCA use, PCAs will be restricted to Role 3 medical units.

c. Role 3 facilities will administer PCA IAW Unit level SOP, consistent with approved clinical practice guidelines. Standardized order and monitoring forms should be utilized.

10-9 ADDITIONAL INFORMATION

a. Hours of Operation: A pharmacist and a pharmacy technician are on-call 24 hours per day, seven days per week to assist nursing or physician staff in providing optimal patient care. The on-call staff can be accessed as per Unit SOP.

b. Order Entry and Times. The pharmacy staff will enter all inpatient prescription orders into the TC2. Unless otherwise specified on the order form submitted and in life-threatening (STAT) cases, the pharmacy department will use standard medication administration times defaulted in TC2. All facility areas requesting non-standard administration times will coordinate with Inpatient pharmacy for time adjustments.

c. Quantities. Pharmacy will prepare and dispense/ deliver quantities of unit doses or parenteral medications based on directions for use, administration times and Unit SOP.

d. Weight-based Dosing. Weight-based dosing will be applied to all patients less than 40 kilograms. This requires that the prescription order accompanied by the patient's weight and the weight-based dose. When appropriate, the weight will be entered in the TC2 comment field.

e. Missing or Late Doses.

(1) If a patient's medication dose is missing, the nurse will report it to inpatient pharmacy. Medications will not be "borrowed" from one patient for another patient.

(2) Medications should be administered as close to the scheduled administration time as possible. In general, a medication is considered late if not administered within one hour of the scheduled administration time. If an alternate dosing schedule is desired, the nurse will coordinate with the inpatient pharmacy.

f. Returns. Medications no longer required in the patient care area (e.g., discharge) will be returned to the inpatient pharmacy as soon as possible. Ward staff should appropriately mark the label of the parenteral product to be returned with the disposition status (e.g., "refused" if patient refuses, "D/C" if discontinued, "extra" if extra dose, "transferred to ###" if transferred to another ward). The above also applies to expired medications.

g. Special Devices.

(1) The Pharmacy will make every attempt to identify in-line filter requirements for use with a parenteral product by making an annotation on the admixture label (e.g., Liposyn, mannitol, phenytoin).

(2) When a mechanical device is used to infuse intravenous preparations, the staff member responsible for actual administration will understand how to operate the device and be able to perform corrective actions to ensure the device is operating correctly.

(3) Needleless transferring and connecting devices will be used whenever possible to reduce the chance of needle sticks.

11-1. The proponent for CCOP-03 is the USCENTCOM Surgeon at 813-529-0345 or DSN 312-529-0345.

MCCORD.LARRY.J.1245112625

Digitally signed by MCCORD.LARRY.J.1245112625
Date: 2024.12.20 11:53:41 -05'00'

LARRY J. MCCORD
COL, MC, USA
COMMAND SURGEON