

# Where is My Prescription?

By Michael Van Ornum, RPh, RN, BCPS

“Where is my prescription?” A simple question, and a bit unexpected in 2010. After all, we’ve had more than a hundred years to perfect the prescriptive process and the most recent advancement, electronic prescribing, makes the process even more efficient. And yet, “Where is my prescription?” The question echoes in an endless loop in the mouths of providers, patients, and pharmacists.

Surescripts reported, in the U.S., 190 million electronic prescriptions routed in 2009 and that amount is growing fast. It’s not uncommon to see more than 1.5 million prescriptions routed on a given day in 2011. The technology has come into its own over the last decade, delivering prescriptions in a legible form directly to the pharmacy – hands free! That should mean fewer calls to the doctor, fewer errors for the patient, and faster filling at the pharmacy. And yet, “Where is my prescription?” lingers like a shadow, hinting at increased – not decreased – phone calls back and forth between prescribers and pharmacies. Patients are told the prescription will be ready the next day by the pharmacist right after leaving the office where they were assured the prescription would be ready and waiting for them. And both prescriber and pharmacy systems squawk in alarm as the prescriptions come across in a constant reminder that safety is not a given in this equation, but a product of vigilance.

These results are not the fault of the good clinicians sending and receiving prescriptions. Nor is it a failing of the technology itself, which performs as it was intended to. If anything, e-prescribing has provided unexpected benefits. Never before have pharmacists and prescribers been so closely linked as in the process of e-prescribing, never before has a technology had such potential to widen the gap between them.

On the prescriber side, the medication, dose, quantity, refills, and more are directly received by the pharmacy system without need for re-typing by the pharmacist. If this were a paper prescription, the prescriber would have no idea when the patient might get around to getting it filled, whether it was held for a few days by the pharmacist, or simply lost.

When the send key is pressed, they know it’s there. So when a prescriber hears, “Where is my prescription?” questions are quick to follow. Was it the e-prescribing system? Does the pharmacy not know their own system? Did it fall into a hole in cyberspace where only socks lost in the dryer exist?

The pharmacist, on the other hand, is put on the defensive almost immediately; usually by a loud and vocal patient. After a quick scan of the usual places, questions are quick to follow. Was it the pharmacy system? Do the prescriber’s not know their own system? And of course, who was the person who told the patient it would be ready for them and do THEY work in the pharmacy?

The challenges, frustrations, and successes of e-prescribing cannot be fully addressed in only one forum. Medicine does not have the answers. Pharmacy does not have the answers. Rather, it is the way pharmacy and medicine work together that holds the key to meaningful use of electronic prescribing. The workflows of the pharmacy and the workflows of the medical office have never been closer, never affected each other so interdependently, and never been in such desperate need of alignment.

The question “Where is my prescription?” is emblematic of the many problems surrounding electronic prescribing as best demonstrated by the many answers to such a simple question:

- It was sent to the wrong pharmacy
- It was never sent at all
- It requires clarification
- It has missing information – sometimes technical, sometimes human oversight
- The pharmacist didn’t see it
- It was delayed in transit – some large pharmacies have a central collecting place for prescriptions before routing them internally to their branch pharmacies
- The fax was turned off – some electronic prescriptions are converted to a fax by pharmacies not yet fully electronic. They can receive electronic prescriptions after a fashion, but it’s not truly electronic.
- It was held for prior authorization

- The pharmacy doesn't have that medication in stock – especially if the prescriber chose an unusual formulation
- There's a mismatch in patient identification – this can hold up the prescription in a separate area of the program until the mismatch is resolved.
- Pharmacy policy dictated a fill later on – some pharmacies routinely fill maintenance medications for the next day. This is a workflow mismatch.

Most of these reasons for missing prescriptions are avoidable and following a few best practices will set the prescriber well on their way to using e-prescribing meaningfully.

1. **Avoid Free Text:** Typing anything by hand opens up the possibility for error and confusion. Select from drop-down lists or other options whenever possible so the drug, directions, dose, or other information is correctly identified.
2. **Watch the dispense quantities:** Inhalers are not dispensed as 1 gm. While it may seem trivial, these kinds of inaccuracies may cost the pharmacy money and put the pharmacy at risk for fraud. An insurer can refuse a bill from the pharmacy for the 17gm inhaler if only 1 gm was ordered, though this usually happens on a retrospective audit. These concerns force the pharmacist to call for clarification, even on issues where the intent is clear, because the documentation is incorrect. Be especially careful of the quantities of inhalers, oral liquids, injectables, topicals, and compounded drugs.
3. **Watch the dispense units:** Some e-prescribing applications automatically populate an incorrect unit such as a carton. This can make a 30 day supply of a daily drug into a dispense quantity of 900 pills if a 30 cartons of 30 each are selected. Conversely, know the drugs that should be dispensed as cartons, such as insulin pens. When in doubt, ask the pharmacist or leave an explanatory note that allows them to change the quantity to an appropriate amount.
4. **Watch the formulation:** Historically, prescribers chose the drug and pharmacists chose the formulation – but e-prescribing forces prescribers to choose the drug AND formulation. For example, metoprolol tartrate is dosed twice daily while metoprolol succinate is once daily. Simply choosing the first metoprolol on a list may result in an error if the wrong formulation is selected.
5. **Watch the route:** It is easy to select the wrong route, especially when medications exist in the same dose

across different formulations. In one instance of wrong route, promethazine tablets were selected for a patient with severe vomiting instead of promethazine suppositories.

6. **Use the comments field:** Pharmacists have an obligation to counsel the patient on the administration, purpose, and potential side-effects (among other things) of the dispensed medication. Whether the metformin is for diabetes or polycystic ovarian syndrome is essential information for that counseling. Propranolol can be used for everything from heart rate control to migraine prevention to blood pressure lowering. Putting the indication for the medication in the comments section or as part of the patient's instruction helps the pharmacist support the treatment plan and increases the safety for the patient. ALSO If a prior authorization number is known for a particular prescription, put that in comments as well. It will save a call back from the pharmacy for the number.

The question "Where is my prescription?" is not an accusation, it is an invitation to prescribers and pharmacists to learn more about each other. It is not to be viewed as a threat, but an opportunity; it is not the whisper of defeat, but a loud call to action.



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