



Navy Pharmacy Standard Operating Procedure

Version 2.0

October 7, 2013



World Class Care....Anytime, Anywhere

Navy Pharmacy SOP: Version 2.0 Change Table

Version 2.0 Change Table

The Change Request Process was utilized to successfully capture, review, approve and incorporate feedback on Version 1.0 of the Navy Pharmacy SOP from members of the Navy Pharmacy community. For additional information on the Change Request Process, refer to [1.5.1 Change Request Process](#).

The Version 2.0 Change Table provides Navy Pharmacy SOP users with an easily accessible overview of revisions that were approved for inclusion within Version 2.0 of the Navy Pharmacy SOP. A detailed change tracker can be accessed on the [Navy Pharmacy NKO Page](#).

Version 2.0 Change Table	
Process	SOP Change
1.2 Scope	Update: Included space for commands to include policy on discharge procedures in 2.5.7 Discharge Medications .
	Update: Deleted command specific policy for "Refill Requests."
	Formatting: Updated formatting throughout the Navy Pharmacy SOP to allow addition of command specific policies as needed. Additional information available on NKO.
2.0 Inpatient Pharmacy Operations	Content Development: Provided clarification for pharmacist prospective review of orders by removing LIP/nurse verification blanket statement.
2.1.3 Perform Profile Review	Clarification: Included a "PRI" option for accessing a patient's prescription record in CHCS.
	Clarification: Included information on how to get to the "PRI" function using the Inpatient Menu in CHCS.
2.2.4 Requirements for Order Entry	Content Development: Updated text to clearly state patient information that must be readily, accessible, and the required elements of a complete medication order.
	Clarification: Included guidance indicating that pharmacy staff must contact the provider or ward staff for clarification to resolve all issues regarding unclear or incomplete orders.
	Clarification: Developed text to indicate that hospitals must have a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment or services.
2.2.5 Must Contact Pharmacist List	Content Development: Developed text to clarify medications that need a pharmacist to be contacted or physically present when prepared by a pharmacy technician and moved <i>Must Contact Pharmacist List</i> to new location in SOP.
2.2.6 Enter Order into CHCS	Clarification: Clarified information included under Transfer of Ward (TOW) to clarify process for review of medication orders into CHCS.
	Clarification: Defined best practices for the documentation of clinical override comments in CHCS.
2.2.7 Review Clinical Warnings	Clarification: Included "contraindication" in review of allergy, duplicate therapy and drug class.
2.2.8 Review Order (LIP/Nurse)	Clarification: Clarified that a retrospective pharmacist review of nurse reviewed orders will occur at the beginning of the next shift, and that a retrospective review of LIP-reviewed orders should occur at the beginning of the shift as a best practice.

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2.3.1 Prepare Inpatient Medication Labels (Patient-Specific Medications)	Content Development: Developed text to state that medications should be labeled with the patient's name, the appropriate expiration date, and the location where the medication is to be delivered.
	Clarification: Removed "Quantity to be dispensed" from label requirements because it is not an inpatient function.
	Clarification: Updated text to include special storage requirements (i.e. refrigerate) and administration instructions, if needed.
2.3.1 Prepare Inpatient Medication Labels (General Ward Stock Medications)	Content Development: Developed text to clearly state that medications are correctly labeled with the appropriate expiration date and the location where the medication is to be delivered.
	Clarification: Clarified that general ward stock medication labels do not need both generic and trade names.
	Clarification: Updated text to include special storage requirements (i.e. refrigerate) and administration instructions, if needed.
2.3.1 Prepare Inpatient Medication Labels (Additional Labeling Requirements)	Content Development: Updated text to include information on Compounded IVs.
	Clarification: Updated text to indicate that additional diligence applies when using Multiple Dose Vials (MDV).
2.3.2 Prepare IV/Injectable Orders	Content Development: Updated text to clarify that when preparing materials for use in sterile preparation pharmacy staff will visually inspect the medication for particulates, discoloration, or other loss of integrity.
	Clarification: Changed the phrase "Preparation of Materials for Use in Sterile Preparation" to "Preparations of Sterile Products".
2.4.2 Verify Preparation Materials	Content Development: Added content to provide guidance on minimum requirements a pharmacist must verify when checking preparation materials.
2.4.3 Verify Preparation Calculations	Content Development: Added content to provide guidance on minimum requirements a pharmacist must verify when checking preparation calculations.
2.4.4 Verify Final Product	Content Development: Added content to provide guidance on minimum requirements a pharmacist must verify when checking the final product to be dispensed.
2.4.6 Correct Order Errors and Perform Edits	Clarification: Updated text to indicate that for all medication order changes, the edit must be documented in the medication order through Essentris.
2.4.7 Verify Order (Pharmacy Technician)	Clarification: Updated text to indicate that a night-duty cell phone or pager shall be issued to a pharmacist for a read-back review of the technician-reviewed order for medications or medication classes that are included in 2.2.5 Must Contact Pharmacist List
2.5 Ward Stocking	Content Development: Updated text to indicate that the pharmacy shall utilize managed processes to prevent unauthorized individuals from obtaining medications.
2.5.3 Stock Crash Cart Trays	Content Development: Updated text to indicate that the local P&T Committee will determine which emergency medications are stored in crash carts and where these crash carts are located.
	Word Change: Change "ward" to "ward/clinic" to encapsulate full inpatient environment.
2.5.5 Perform Discrepancy Resolution	Clarification: Provided additional guidance for resolving discrepancies for ADCs, to include Schedule II medications.

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Process	SOP Change
2.5.6 Return Inpatient Medications to Pharmacy	Clarification: Provided additional guidance for resolving discrepancies for unit dose carts or patient specific bins, to include scheduled medications.
2.5.7 Discharge Medications	Clarification: Updated text to include space for the Pharmacy Department Head to include command policy regarding discharge procedures.
3.1.1 Patient Queuing	Clarification: Updated text to include “Equivalent Tool” as an alternative option for patient queuing.
	Content Development: Updated text to provide additional examples of how queuing tickets can be allocated and weighted to improve continuity of services among all beneficiaries.
3.1.2 Patient Identification	Clarification: Removed "verify" from process title. Verification occurs during critical duty 3.4, not during initial patient check in processes.
	Clarification: Updated text to include information on allowed photocopying of ID cards to facilitate DoD benefits.
3.1.2 Patient Identification	Content Development: Updated text to indicate that pharmacy personnel are empowered to use professional judgment to make exceptions for a patient who forgets to bring or does not have a photocopy or electronic copy of the other beneficiary's valid government-issued identification card.
3.1.3 Patient Eligibility	Clarification: Remove "verify" from process title. Verification occurs during critical duty 3.4, not during initial patient check in processes.
	Clarification: Updated text to indicate pharmacy staff shall contact their local patient administration department for additional guidance on patient eligibility if needed.
3.1.4 Patient Prescriptions	Clarification: Remove "verify" from process title. Verification occurs during critical duty 3.4, not during initial patient check in processes.
3.1.5 Patient Allergies	Clarification: Remove "verify" from process title. Verification occurs during critical duty 3.4, not during initial patient check in processes.
3.1.6 Patient Weight	Clarification: Remove "verify" from process title. Verification occurs during critical duty 3.4, not during initial patient check in processes.
3.1.7 Perform Pregnancy/Lactation Query	Clarification: Updated text to provide two options for pregnancy sign verbiage.
3.2 Prescription Entering and Processing	Content Development: Developed content to include appropriate guidance about IDC prescribing.
3.2.1 Prescription Information Requirements	Content Development: Updated text to clarify that patient information and the required elements of a complete prescription must be readily accessible.
3.2.3 Process Hard Copy Prescription	Clarification: Updated text to clarify that in locations where hard copy prescriptions are manually verified rather than scanned, a different-colored pen must be used by the pharmacist.
3.2.3 Process Hard Copy Prescription (Entering a New Provider into CHCS)	Clarification: Updated text to note that if the NPI ID is not located on the prescription, pharmacy staff can reference the National Plan & Provider Enumeration System (NPPES)’s NPI Registry Search function to locate this information.
3.2.4 Process Prescription Transfer Request	Content Development: Updated text to include reference to Appendix E, Pharmacy Forms and Templates, to access a copy of the prescription transfer form.
	Clarification: Updated text to note that pharmacy staff at the receiving MTF should ensure that the prescription is not active at the transferring MTF.
	Clarification: Updated language to note that prescriptions shall be transferred to and from retail pharmacies in accordance with state law.

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3.2.5 Process Non-Formulary Prescription Request	Content Development: Updated text to indicate that staff can refer to the Department of Defense Pharmacoeconomic Center (PEC) for the development of local criteria and templates for Medical Necessity and Prior Authorization Forms. Furthermore, Pharmacy staff shall record pharmacist review and approval.
3.2.6 Process Walk-Up Refill Request	Clarification: Updated text to indicate that when Emergency Refills are approved, pharmacy staff should document them in CHCS.
3.2.8 Review Clinical Warnings	Clarification: Updated text to indicate that all interaction and moderate warning messages shall be retrospectively reviewed by a pharmacist via override reports when prospective review is not available.
3.2.9 Correct Prescription Errors and Perform Edits	Clarification: Updated text to clarify that for hard copy prescriptions, the pharmacy staff shall also document any changes on the CHCS label and on the front of the prescription in different colored pen and note his or her initials (or other unique identifier).
3.3.4 Prepare Prescription Labels	Clarification: Updated text to clarify that only the prescription filler's initials or numeric identifier (when not supported through automation) are required.
3.5.1 Verify Patient Identification	Content Development: Updated text to indicate that pharmacy personnel are empowered to use professional judgment to make exceptions for a patient who forgets to bring or does not have a photocopy or electronic copy of the other beneficiary's valid government-issued identification card.
3.5.5 Dispense Over-the Counter (OTC) Medication	Content Development: Included guidance on Tobacco Cessation (TC) prescribing policy and TC pharmacotherapy availability pharmacy.
3.5.6 Dispense Brig Patient Prescriptions	Clarification: Updated text to indicate that a brig staff member must sign the back of every Schedule-II prescription collected, or capture signature via an electronic signature pad, to confirm receipt.
3.5.7 Return to Stock	Clarification: Updated text to clarify those Schedule-II-V prescriptions that are returned to stock should be secured with, not returned to, the controlled substance working stock to maintain inventory best practices.
	Clarification: Updated text to indicate that when medication is returned to stock, pharmacy staff must ensure physical destruction of the patient's name and corresponding label material on the prescription vial to prevent any future identification of the patient from the prescription label. Previous SOP language inadvertently set pharmacy staff up for potential HIPAA violation. Supplemental Guidance was released on 29 May 2013, and incorporated into the text of Version 2.0.
	Content Development: Updated text to provide keystrokes in CHCS to offer sites guidance on how to mark RTS prescriptions as noncompliant.
	Clarification: Updated text to remove reference to USP 795 in 3.5.7 Returning to Stock.
4.1.1 Prepare for Remote Pharmacist Final Verification	Clarification: Updated text to indicate that after completing the prescription filling procedures (3.3 Prescription Filling) and reviewing clinical warnings (3.2.8 Review Clinical Warnings), the pharmacy technician at the Remote Site prepares medications for remote verification by the Support Site pharmacist.
5.0 Batch Refill Pharmacy Operations	Clarification: Updated text to eliminate space for commands to specify use of AudioCare. Instead, pharmacies may require patients to use automated refill request systems to request prescription refills.
5.3 Batch Refill Final Verification	Clarification: Updated text to indicate that refill prescriptions may be checked by either a pharmacist or a pharmacy technician. It is required, however, that the filling technician not be the same pharmacy staff member as the final verification technician.
6.1 Manage Pharmacy Supply	Content Development: Provided additional language to guide staff in the case of FDA recalls as well expectations for appropriate quantities of medication to maintain.

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Process	SOP Change
	Content Development: Added language regarding the communication of medication shortages and outages.
	Content Development: Added language to provide procurement guidelines for non-formulary medications.
	Update: Updated SOP language to align with guidance provided in “Ordering Officer Requirements Guide for DLA Ecommerce Contracts.”
6.1.2 Establish and Modify Stocking Levels	Content Development: Developed content to include information on non-stocking or deleting items, adding a new item to the catalog, and printing barcodes.
	Clarification: Clarified language to state that all items are set to static in the DMLSS catalog and that sites do not have to order each item every day.
	Clarification: Added additional language to clarify when ordering should occur and the importance of properly set re-order points.
	Clarification: Added additional language to clarify that staff can utilize an NDC or drug name to search in the DMLSS catalog.
	Content Development: Developed additional content, including step-by-step directions, to include information on non-stocking or deleting items, adding a new item to the catalog, and printing barcodes.
6.1.3 Procure and Order Pharmacy Supply	Content Development: Developed additional content, including step-by-step directions, to include information on how to utilize status edits.
	Updated DMLSS Screen Shots: Replaced DMLSS Screenshot and the corresponding explanations to reflect software update.
6.1.4 Receipt Pharmacy Supply Order	Clarification: Added additional text to clarify alignment with the separation of function guidance in M8 Prime Vendor Management SOP and clarify how pharmacy Shelf Count process meet established requirement.
	Updated DMLSS Screen Shots: Replaced DMLSS Screenshot and the corresponding explanations to reflect software update.
6.1.5 Manage DMLSS Catalog	Content Development: Included additional information to reiterate the importance of maintaining the DMLSS catalog.
6.4 Manage Drug Shortages	Content Development: Included a new section with guidelines for managing medication shortages. The section includes the following processes: Conduct Operational Assessment, Conduct Therapeutic Assessment, Analyze Impact of Shortage, Communicate Finalized Plan, Implement Plan, and Drug Shortage Resolution .
7.1.6 Committee Involvement	Content Development: Updated text to provide additional guidance on the use and purpose of the local P&T Committee.
7.1.10 Pharmacy Management Reports	Content Development: Updated text to provide additional information on how pharmacy staff can utilize appropriate literature and other external sources. to learn about best practices and take action on opportunities for improvement.
7.1.11 Lot Number Generation	Clarification: Updated text to indicate that pharmacy staff shall use the following equation to generate lot numbers: [four digit of year] + [two digit of month] + [two digit of day] + [# of unit dose product for that day] + [n=narc/control, c=outpatient compound, u=inpatient unit dose and i=IV batches].
7.2.6 Professionalism and Conduct	Clarification: Updated text to indicate that the Patient's Bill of Rights and Responsibilities should be posted outside the pharmacy.

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7.4.2 ADC Order Entry Management (ADC Settings and Access)	Content Development: Updated text to indicate that the list of pharmacy and ward staff with ADC access shall be verified with the appropriate department, division, clinic, or ward supervisors to ensure that individuals listed remain employed within the role under which they were granted access. On a periodic basis, to be determined by the facility, access rosters should be reviewed with nursing representatives to ensure ADC access is limited to current personnel and proper location.
7.4.2 ADC Order Entry Management (ADC Override Medication List)	Clarification: Updated text for retrospective reviews of overridden medications, to specify daily review.
7.5.1 Downtime Procedures (Computer Downtime Procedures)	Clarification: Updated text to indicate that during computer downtime situations ADCs shall be placed on Critical Override or medications will be provided directly to the ward as directed by the Pharmacy Department Head.
7.5.1 Downtime Procedures (DMLSS Downtime Procedures)	Content Development: Developed content to provide information on manage different DMLSS downtime scenarios.
7.5.2 Emergency Management	Content Development: Developed content to further explain additional emergency scenarios.
7.7.1 Pharmacy Safety	Content Development: Updated text to include additional information on High Alert Medications (HAMs).
	Clarification: Updated text to indicate that examples of appropriate labeling include “Name Alert” and “LASA.”
7.7.2 Hazardous Material Program	Content Development: Developed content to include minimum guidelines on how to safely dispose hazardous materials.
7.7.3 Patient Safety Program	Content Development: Updated text to indicate that if a patient safety event is medication related, the Pharmacy Department Head or designee will be requested to review the event and answer questions within the PSR tool. This section also highlights the role of the P & T Committee in these events.
7.7.8 Expired, Damaged, and/or Contaminated Medications	Clarification: Updated process title from “Expired Medications” to “Expired, Damaged, and/or Contaminated Medications” to appropriately capture information provided.
	Content Development: Updated text to provide guidance on appropriate reverse distribution procedures for expired medications.
7.7.9 Infection Control (Pharmacy Environment)	Clarification: Updated text to provide additional guidance on pharmacy cleaning standards.
7.7.9 Infection Control (Personnel)	Content Development: Developed text to indicate that pharmacy staff will maintain a neat and clean appearance by following minimum attire, hand washing, and personal hygiene procedures.
7.7.9 Infection Control (Sterile Products Program)	Clarification: Updated text to indicate that MTFs that utilize an enclosed and vented BSC outside of a clean room can disregard the PPE requirement.
8.1.2 Prepare Sterile Compounded Medication	Content Development: Updated text to indicate that a pharmacist, or pharmacy staff under the supervision of a pharmacist, shall compound or admix all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product’s stability is short.
9.1 Controlled Substance Prescription Preparation, Filling, and Dispensing	Content Development: Updated text to indicate that MTFs shall use the standardized dispense, inventory, and requisition forms to audit and monitor Schedule-II drugs and additional drugs determined by the Commanding Officer (CO) to be treated like a Schedule II drug from receipt into inventory until dispensing.

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Process	SOP Change
Appendix A (Preparation of Chemo and Anti-Neoplastic Orders)	Clarification: Updated text to indicate when the chemo-isolator or hood should be cleaned.
Appendix C	Content Development: Updated glossary to include guidance on the term “Current Medications” as it relates to the National Patient Safety Goals (Hospital Accreditation Program) effective January 2013.
Appendix D	Formatting: Changed hyperlinks from black to blue.
Appendix E (Ward Inspection Report)	Clarification: Updated text to clarify guidance provided in the “Key,” Item #5. This can relate to any ADC, not just Pyxis.
Appendix E (Prescription Transfer Request Form)	Content Development: Updated text to include a template for the Prescription Transfer Request Form.
Appendix F	Content Development: Provided additional resource to define documentation of comments in CHCS clinical overrides.
Appendix G	Content Development: Developed The Joint Commission (TJC) Crosswalk (<i>Table G-1: TJC Crosswalk</i>) to provide a clear and easy to use reference that will support site adherence to TJC requirements.

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Navy Pharmacy SOP: Introduction

1.0 INTRODUCTION

This introduction provides general information related to the Navy Pharmacy Standard Operating Procedure (SOP), including:

1.1 [Objective](#)

1.2 [Scope](#)

1.3 [Accountability](#)

1.4 [SOP Structure](#)

1.5 [SOP Sustainment and Updates](#)

1.6 [Contact Information](#)

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Navy Pharmacy SOP: Introduction

1.1 Objective

The Navy Pharmacy SOP provides for a Navy-wide standardization of pharmacy policies and procedures, which benefits both patients and staff. The SOP provides a comprehensive point of reference, in conjunction with the [Manual of the Medical Department \(MANMED\) Chapter 21: Pharmacy Operation and Drug Control](#), and professional clinical judgment, to facilitate a uniform delivery of the pharmacy benefit.

An enterprise-wide SOP provides multiple benefits to the Navy Pharmacy community and its patients. By incorporating best practices from across the enterprise and defining a standard delivery of pharmacy care, Navy Pharmacy can enhance the quality of care and deliver an improved, safer pharmacy patient experience.

Benefits resulting from standardization include, but are not limited to:

- **Reducing training time** for pharmacists and pharmacy technicians when changing duty stations.
- **Improving patient safety** by implementing “best practices” into the daily clinical practice.
- **Improving patient experience** by providing a consistent, patient-focused delivery of pharmaceutical care.
- **Facilitating regulatory compliance** by aligning pharmacy operations with current Joint Commission standards and federal regulations.

Note: The TRICARE pharmacy benefit is provided to all eligible Uniformed Services members, including certain TRICARE for Life (TFL) beneficiaries. Eligible beneficiaries of the pharmacy benefit may fill a prescription at a Military Treatment Facility (MTF) without incurring out of pocket costs, or they may elect to use a non-military pharmacy with payment of identified co-pay. For further information on the pharmacy benefit, refer to the [TRICARE Pharmacy Program](#).

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Navy Pharmacy SOP: Introduction

1.2 Scope

The Navy Pharmacy SOP is applicable enterprise-wide and is inclusive of all Navy Pharmacy Activities. The Navy Pharmacy SOP governs all pharmacy staff as they perform their pharmacy duties within the Navy Pharmacy enterprise. Additionally, this SOP provides processes and procedures that apply to non-pharmacy staff as they interact with the pharmacy, including patients and inpatient ward staff.

The Navy Pharmacy SOP supersedes individual site SOPs; however, this SOP allows for pharmacies to input additional Command and Departmental policies where appropriate. The Pharmacy Department Head is responsible for ensuring that the following Command policies are provided, if applicable according to Command capacity and scope of service:

- *Batch Refill Delivery:* Command policies on local delivery of batch refill medications by pharmacy personnel and the transportation policy and delivery schedule should be provided in [5.4.1 Batch Refill Prescriptions](#) and [5.4.2 Deliver Batch Refill Prescriptions](#), respectively.
- *Batch Refill Labels:* Pharmacy policy on the frequency with which pending batch refill prescription labels are downloaded for further processing and printing should be provided in [5.1.4 Print Batch Labels](#).
- *Discharge Procedures:* Command policy on discharge procedures should be provided in [2.5.7 Discharge Medications](#).
- *Drugs with a High Potential for Diversion (DHPD):* Command list of locally-selected DHPDs should be provided in [9.0 Controlled Substances](#).
- *Hazardous Materials:* Command list of hazardous materials should be provided in [7.7.2 Hazardous Materials Program](#).
- *High-Alert Medications:* Command list of high-alert medications should be provided in [7.7.1 Pharmacy Safety](#).
- *Hours of Operation:* Command hours of operations should be provided in [7.1.2 Hours of Operation](#).
- *Look-Alike/Sound-Alike Medications (LASA):* Command list of LASA medications should be provided in [7.7.1 Pharmacy Safety](#).
- *Override Medication List:* Command override medication list, as determined by the Command Pharmacy and Therapeutics (P&T) Committee, should be provided in [7.4.2 ADC Order Entry Management](#).
- *Personal Property:* Command policies on personal property and abandoned property should be provided in [7.7.10 Personal Property](#) and [7.7.11 Abandoned Property](#), respectively.

Navy Pharmacy SOP: Introduction

- *Pharmacy Department Organizational Structure:* Pharmacy department organizational structure should be provided in [7.2.1 Pharmacy Department Organizational Structure](#).
- *Prescription Pick-Up:* Command policy on appropriate age to pick up a personal prescription should be provided in [3.1.2 Patient Identification](#).

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Navy Pharmacy SOP: Introduction

1.3 Accountability

The Pharmacy Department Head is responsible for ensuring that their staff adheres to all policies and procedures included in the Navy Pharmacy SOP. Exceptions to these policies and procedures may be authorized, according to the pharmacists' clinical and professional judgment.

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Navy Pharmacy SOP: Introduction

1.4 SOP Structure

The Navy Pharmacy SOP provides instructions for pharmacy leadership and staff as they execute standardized procedures in accordance with best practices, policies, and guidance. The Navy Pharmacy SOP is structured as follows:

- *Section*: The division in which the pharmacy staff member is operating.
 - The eight Sections included in the Navy Pharmacy SOP are Inpatient Pharmacy Operations, Outpatient Pharmacy Operations, Telepharmacy Operations, Batch Refill Pharmacy Operations, Supply Operations, Administrative Operations, Compounding Operations, and Controlled Substance Operations.
- *Critical Duty*: A collection of key roles and responsibilities within a pharmacy division.
- *Process*: A specific set of actions required to complete each responsibility.
- *Tasks*: Requirements to complete a process.

Content within this SOP can be edited only when it relates to policies and procedures specific to individual Pharmacy Departments. These areas are identified throughout the document.

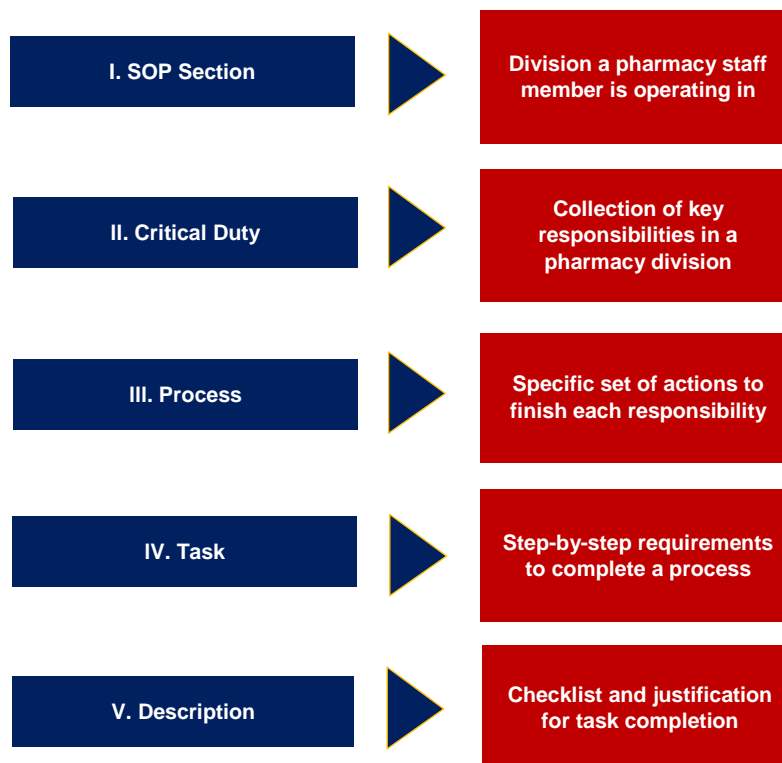


Figure 1.4-1: Navy Pharmacy SOP Structure

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Navy Pharmacy SOP: Introduction

1.5 SOP Sustainment and Updates

The Navy Pharmacy SOP is a living document that will adapt to changing laws and policies, and will be updated when new best practices are identified and approved by Navy Pharmacy leadership. The Navy Pharmacy community is encouraged to be actively involved in the Navy Pharmacy SOP sustainment process.

1.5.1 Change Request Process

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Navy Pharmacy SOP: Introduction

1.5.1 Change Request Process

To suggest a change to the Navy Pharmacy SOP, members of the Navy Pharmacy community must complete the standard Navy Pharmacy SOP Change Request form, which can be found in Appendix I as well as on the [Navy Pharmacy NKO Page](#). This form must be completed in its entirety and returned to the BUMED Pharmacy SOP Mailbox:

BUMED.PharmacySOP@med.navy.mil. One form must be completed for each change request.

- **“Priority 1”** encompasses requests that are considered as requiring immediate attention due to their immediate impact on patient safety or compliance with a DoD directive.
- **“Priority 2”** encompasses all other requests for updates to the SOP that are not time-sensitive and do not directly impact patient safety or compliance with a DoD directive.

Upon acceptance of a change request, the approved content will be entered into Version 3.0 of the Navy Pharmacy SOP and announced on NKO. If a change request is not recommended for inclusion, the NPAB Chair will communicate the reason to the requestor. Figure 1.5.1-1 provides a graphical depiction of this change request process.

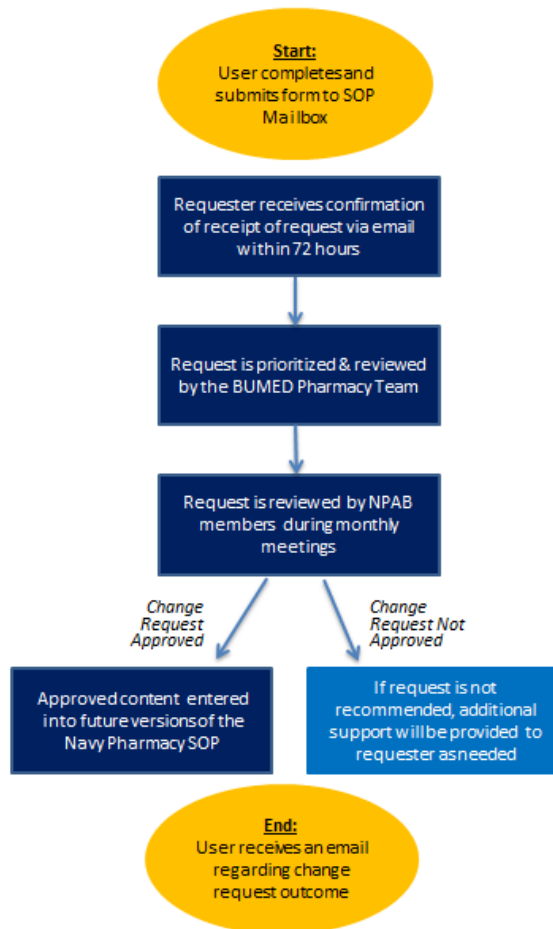


Figure 1.5.1-1: Navy Pharmacy SOP Change Request Process

Navy Pharmacy SOP: Introduction

1.6 Contact Information

For questions related to the Navy Pharmacy SOP, contact the BUMED Pharmacy SOP Team at BUMED.PharmacySOP@med.navy.mil.

Additional information on the Navy Pharmacy SOP can be found at the following:

- [Navy Pharmacy Community SharePoint Page](#)
- [Navy Pharmacy NKO Page](#)

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Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.0 INPATIENT PHARMACY OPERATIONS

The procedures stated within this Section of the Navy Pharmacy Standard Operating Procedure (SOP) apply to inpatient pharmacy operations. Pharmacy staff will follow these procedures when preparing and filling medication orders for inpatient use, and when operating within an inpatient environment.

Five Critical Duties exist related to inpatient pharmacy operations:

2.1 [Patient Arrival and Admission](#)

2.2 [Order Review](#)

2.3 [Order Filling](#)

2.4 [Order Final Verification](#)

2.5 [Ward Stocking](#)

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Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.1 Patient Arrival and Admission

Upon arrival at the hospital, a patient is evaluated and admitted to the hospital as an inpatient or assessed for an Ambulatory Procedure Visit (APV). Patients admitted to a hospital ward have a Composite Health Care System (CHCS) inpatient profile created by Patient Admissions to track and monitor medication orders. Admission of a patient through CHCS will automatically transfer the appropriate patient information into the Automated Dispensing Cabinet (ADC) system, such as Pyxis or Omnicell. If the patient's profile is found to be incomplete, pharmacy staff will notify the ward, who will contact Patient Admissions to complete the required information. Refer to [7.4.1 ADC Patient Settings](#) for further information on entering patients into the ADC.



[MM03.01.05/1](#)
[MM03.01.05/2](#)

It is the responsibility of the ward staff to collect any medications brought by the patient to the hospital at the time of admission. When possible, medications collected in this manner will be returned to a family member of the patient with instructions to return the medications to the patient's home for safekeeping. All medications collected in this manner must be appropriately documented in accordance with Command policy. **The Pharmacy Department Head is responsible for ensuring that Command policy on personal property is provided.** Refer to [7.7.10 Personal Property](#) to access your Command's policy on personal property.

Medications brought from home may only be retained for use if the provider writes an order stating that the patient may use his or her own medication while admitted. In this instance, the following procedures must be adhered to:

- ✓ A pharmacist, licensed independent practitioner (LIP), or nurse with documented competency must physically review and identify all medications before they are authorized for patient use.
- ✓ The pharmacist/LIP/nurse shall make an annotation on the medication in Essentris stating that he or she has physically verified the medication identification.
- ✓ Once authorized, the medications must be stored in a lockable storage area or in the pharmacy.
- ✓ Medications may be returned to the patient upon discharge if authorized by the discharging provider.

Medications not authorized for return to the patient, or remaining after an identified amount of time following patient discharge, shall be destroyed following local destruction procedures and guidance provided in [7.7.7 Disposal of Pharmaceutical Waste](#) and in accordance with the Command policy on abandoned property. **The Pharmacy Department Head is responsible for ensuring that Command policy on abandoned property is provided.** Refer to [7.7.11 Abandoned Property](#) to access your Command's policy on abandoned property.

Note: This policy is not intended to promote active acceptance of medications (i.e., controlled substances), but rather to address medications that have been abandoned by inpatients.

2.1.1 [Classify Patient Admission Status](#)

2.1.2 [Prioritize New Patient Medication Order](#)

2.1.3 [Perform Profile Review](#)

Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.1.1 Classify Patient Admission Status

A patient is classified as either an inpatient or APV patient. This classification will be performed by hospital clinicians and noted in the patient's medical record.

- *Admission of Patient to Inpatient Ward:* Patient is admitted to the hospital as an inpatient and an Essentris and inpatient CHCS profile is created to track and monitor medication orders. The patient's CHCS profile will automatically link to the ADC.
 - If the patient's CHCS profile fails to automatically transfer to the ADC, pharmacy staff will manually enter the patient's CHCS profile into the ADC. Refer to [7.4.1 ADC Patient Settings](#) for further information on manually entering patients into the ADC.
- *Admission of Patient for an APV or Same-Day Surgery:* Patients that arrive at the hospital for an APV or same-day surgery are received by the inpatient hospital staff but are not admitted to the hospital if their length of stay and treatment totals less than 24 hours. APV and same-day surgery patients' medication is tracked under the outpatient tab of their inpatient CHCS profile. When necessary, pharmacy staff may activate the ADC to allow ward staff to remove entered orders for 2359 patients.
 - *Classification of Patient Status as "2359":* Classification of a patient as 2359 by ward staff denotes that the patient's length of stay and treatment will total less than 24 hours.

Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.1.2 Prioritize New Patient Medication Order



All new patient medication orders shall be prioritized following the guidelines below:

- *“STAT” Orders*: Prioritize STAT orders before all others, and begin processing immediately.
 - STAT orders shall be considered as requiring urgent attention. Pharmacy staff shall strive to complete STAT orders within 15 minutes, but no longer than 30 minutes, from pharmacy receipt of the order, provided that safety and circumstances allow.
- *“NOW” Orders*: Prioritize all NOW orders after STAT orders have been processed.
 - NOW orders will be completed within 60 minutes from pharmacy receipt of the order, provided that safety and circumstances allow.
- *“Routine” Orders*: Prioritize all routine orders after STAT and NOW orders have been processed.
 - Routine orders will be completed within 120 minutes (2 hours) from pharmacy receipt of order, provided that safety and circumstances allow.

Further prioritization may be necessary within each timeline, based on patient location, medication type or other differentiating factors (i.e., antibiotics, baby medications, Emergency Department (ED) orders). Pharmacy staff shall use their clinical judgment when prioritizing the orders.

Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.1.3 Perform Profile Review



[MM05.01.01/5](#)

The following steps, in support of the provider's medication reconciliation, shall be taken for all newly admitted patients:

- ✓ *Obtain information on the patient's active prescriptions:* The pharmacist confirms which prescriptions are active within Essentris. The pharmacist reviews the medications for patient appropriateness based on admission diagnosis and patient-specific factors, including but not limited to:
 - Age
 - Gender
 - Renal function
 - Liver function
 - Allergies
 - Drug-drug interactions
 - Drug-food interactions



[MM04.01.01/3](#)

[MM05.01.01/6](#)

Verification of drug dose, route, frequency, and parameters (e.g., hold orders for antihypertensives) shall occur. Facility policy, scope of practice (e.g., IV pressor drip ordered on MedSurg unit) and Medication Management/Joint Commission criteria (i.e., indication requirements) will be verified.

- ✓ *Verify patient's prior and home medication information:* To verify that this information was appropriately completed by the provider, the pharmacist (or pharmacy technician when no pharmacist is present) also accesses the patient's Pharmacy Data Transaction Service (PDTS) profile. The PDTS profile contains the patient's outpatient medication history for the past 180 days and can be accessed by selecting the "PRI" or "DPRX" function in CHCS.

The patient's prior and home medication information can also be verified by accessing the Inpatient Menu in CHCS and utilizing the following steps:

- ✓ Select Enter / Maintain Inpatient Orders
- ✓ Select Patient Name
- ✓ Enter "DPRX" at action prompt
- ✓ Enter "5" for 180 day profile
- Note: PDTS provides a record of prescriptions, but does not indicate whether the patient received the medication. Additionally, prescriptions that are not obtained

Navy Pharmacy SOP: Inpatient Pharmacy Operations

using the TRICARE benefit (e.g., purchased with cash or using Other Health Insurance (OHI)) will not display in PDTS. Should concerns arise regarding the patient's prescriptions, pharmacy staff will contact the dispensing pharmacy to verify that the medication was dispensed to the patient.

- ✓ *Compare medication information (if applicable):* The pharmacist compares the pending medication order with the patient's medication history and determines whether the order will interact with the patient's active prescriptions and/or medications the patient is taking at home. The pharmacy shall take steps to mitigate any potential drug interaction or adverse reaction discovered during this profile review process. Discrepancies between newly written orders and prior and home medications may require further action.
- ✓ *Communicate:* The results of the profile review shall be communicated to the provider if unexplained discrepancies exist. Follow-up actions regarding these discrepancies should be documented in the medication reconciliation note in Essentris (if utilized) after the discrepancy has been resolved, for visibility by pharmacy and other staff. Medications will not be verified in Essentris, activated in ADCs, or dispensed from the pharmacy if discrepancies exist.
 - Note: If the concern is serious and may potentially cause harm to the patient, the results of the profile review should also be communicated to the appropriate provider and/or nursing staff along with stating the reason for the medication delay.
- ✓ *Document:* The pharmacist records profile review completion by signing the medication reconciliation note in Essentris (if utilized) and recording the date and time of completion on the Essentris Status Board (if utilized). The pharmacist indicates profile review has been performed by verifying the medication orders in Essentris.

If Essentris is unavailable, the pharmacist records completion of the profile review on the paper order and includes the following information:

- Name or initials of pharmacist completing the profile review
- Date and time of the profile review completion
- A notation that no issues were found, or a note for the provider detailing any issues found during the profile review



Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.2 Order Review

The inpatient pharmacy enters all new patient medication orders documented on the ward into CHCS, reviews clinical drug warnings, and provides verification of edits to all medication and patient information for each unique order.

2.2.1 Process “STAT” Orders

2.2.2 Process “NOW” Orders

2.2.3 Process “Routine” Orders

2.2.4 Requirements for Order Entry

2.2.5 Must Contact Pharmacist List

2.2.6 Enter Order into CHCS

2.2.7 Review Clinical Warnings

2.2.8 Review Order (LIP/Nurse)

2.2.9 Correct Order Errors and Perform Edits

2.2.10 Inpatient Downtime Procedures

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.2.1 Process “STAT” Orders

STAT orders shall be considered as requiring urgent attention. Pharmacy staff shall strive to complete STAT orders within 15 minutes, but no longer than 30 minutes, from pharmacy receipt of the order provided that safety and circumstances allow. In the event that numerous STAT orders arrive at the inpatient pharmacy at the same time, the pharmacy staff shall use their clinical judgment to prioritize the orders.

The pharmacy will communicate this timeframe to the ward, as needed, to set a general expectation on when STAT orders will be completed by the pharmacy. Communication to the ward regarding individual STAT orders is only required when the pharmacy is unable to meet this expected timeframe.

Further prioritization may be necessary, based on patient location, medication type or other differentiating factors (i.e., antibiotics, baby medications, ED orders).

2.2.2 Process “NOW” Orders

If there are no STAT orders pending, the inpatient pharmacy processes the NOW orders. Pharmacy staff shall use clinical judgment to prioritize NOW orders.

NOW orders will be completed within 60 minutes from pharmacy receipt of order, provided that safety and circumstances allow. In the event that numerous NOW orders arrive at the inpatient pharmacy at the same time, the pharmacy staff shall use their clinical judgment to prioritize the orders. The pharmacy will communicate this timeframe to the ward, as needed.

Further prioritization may be necessary, based on patient location, medication type or other differentiating factors (i.e., antibiotics, baby medications, ED orders).

2.2.3 Process “Routine” Orders

If there are no STAT or NOW orders pending, the inpatient pharmacy processes the routine orders. Pharmacy staff shall use clinical judgment to prioritize routine orders.

Routine orders will be completed within 120 minutes (2 hours) from pharmacy receipt of the order, provided that safety and circumstances allow. In the event that numerous routine orders arrive at the inpatient pharmacy at the same time, the pharmacy staff shall use their clinical judgment to prioritize the orders. The pharmacy will communicate this timeframe to the ward, as needed.

Further prioritization may be necessary, based on patient location, medication type or other differentiating factors (i.e., antibiotics, baby medications, ED orders).

Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.2.4 Requirements for Order Entry



[MM01.01.01/1](#)

[MM05.01.01/7](#)

When reviewing all new pharmacy-prepared inpatient orders, the following must be readily accessible:

- ✓ Two patient identifiers:
 1. Name AND
 2. Date of birth OR Department of Defense (DoD) identification number OR social security number
- ✓ Gender
- ✓ Diagnoses
- ✓ Current Medications
- ✓ Patient allergies and sensitivities
- ✓ Patient weight in kilograms (for pediatric patients age 12 and under, and weight-specific medications)
- ✓ Patient height (when necessary)
- ✓ Pregnancy and lactation information (when necessary)
- ✓ Laboratory results (when necessary)
- ✓ Patient location (if known)



[MM04.01.01/2](#)

Current standards require all inpatient medication orders to include the following information:

- ✓ Two patient identifiers:
 1. Name AND
 2. Date of birth OR Department of Defense (DoD) identification number OR social security number
- ✓ Date/time written
- ✓ Generic or brand name of the medication
- ✓ Form of the medication
- ✓ Indication (when required by local policy)

In situations where the pharmacy is awaiting provider or ward staff clarification on an order, and when applicable, a note shall be included on the Essentris Status Board (if utilized) to alert pharmacy staff to the reason a pending order has not been verified.

Navy Pharmacy SOP: Inpatient Pharmacy Operations

- ✓ Dosage size or strength (in metric units)
- ✓ Dosing schedule
 - Dosing schedule shall not include double-ranges (an example of a double-range dosing schedule is: “Take 1-2 pills 3-4 times daily”) or “Do Not Use Abbreviations” (i.e. QID or QD)
- ✓ Provider name
- ✓ Provider initials (in Essentris) OR signature (hard copy orders)
- ✓ Patient allergies



[MM04.01.01/5](#)

[MM04.01.01/6](#)

[MM05.01.01/11](#)

If an order is incomplete or unclear, pharmacy staff must contact the provider or ward staff for clarification to resolve all concerns, issues, or questions. The medication will not be dispensed until all questions regarding the order have been answered. Pharmacy staff will advise the provider or ward staff of the confusion. Once the provider has made the change in Essentris, pharmacy staff shall proceed with entering the order into CHCS.

All verbal orders or clarifications given by the provider or ward staff must be taken by a pharmacist and written down immediately. Verbal orders should only be accepted in emergent cases.

All orders must be reviewed by a pharmacist before being released to the nursing staff (with exceptions noted below).

Orders received after hours will be verified as soon as the pharmacist reports for duty at the next shift. If at any time the duty pharmacy technician has any questions regarding an order, they are to call the duty pharmacist or shift supervisor for guidance or clarification.

During hours without pharmacist coverage, all order changes or clarifications must be completed by the provider before the pharmacy staff can enter the order into CHCS.



[MM04.01.01/8](#)

Finally, in accordance with current Joint Commission Provision of Care, Treatment, and Services Standards, hospitals are required to have a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment or services.

- When a patient transfers to another ward, a review of medications and/or medication reconciliation can be facilitated through various channels.
 - For example, the Order Enterer can re-write the medication order, sign the medication order as reviewed, or include a written note or medication instruction statement in the TOW orders to communicate a personal review of medications.

Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.2.5 Must Contact Pharmacist List



MM02.01.01/6
MM05.01.01/1
MM05.01.13/6

Certain medications and medication classes require that a pharmacist be contacted or physically present to review the order prior to dispensing. The following is a list of medications and medication classes for which the pharmacist must be either called on or physically present prior to dispensing. Medications under the “Must Contact Pharmacist” list require the pharmacy technician to call the pharmacist for verification. Medications under the “Pharmacist Must Be Physically Present” list require that the pharmacist physically oversees and verifies orders and preparation materials.

However, pharmacy technicians must also call for any other medications/doses they are not comfortable with or have questions about. Individual Commands may choose to require pharmacist contact for additional items, based on scope of services provided, and experience and proficiency of individual pharmacy technicians.

The pharmacy must have a list of standardized intravenous drip concentrations as defined by the Pharmacy Department Head. Items on this list do not require that a pharmacist be contacted or physically present. A template of a standardized intravenous drip concentrations list can be accessed on the [Navy Pharmacy NKO Page](#).

Must Contact a Pharmacist	Pharmacist Must Be Physically Present
Pediatric intravenous medications, oral and parenteral medication doses outside of pre-established acceptable ranges as defined by the Pharmacy Department Head	Injectable chemotherapies (excluding methotrexate for non-cancer use) and Bacillus Calmette-Guerin (BCG)
Insulin continuous (drips) intravenous infusions (non-standard concentrations)	Adult total parenteral nutrition (TPN) (D10W can be used as a start for adult TPN until a pharmacist is present)
Parenteral therapeutic doses of heparin (all intravenous and all subcutaneous doses of heparin above 10,000 units), low molecular weight heparins (e.g., subcutaneous doses of enoxaparin above 40mg), glycoprotein IIb/IIIa, factor Xa and direct thrombin inhibitors when P&T Committee approved protocols and/or smartpump protections do not exist	Neonatal Intensive Care Unit (NICU) and Pediatric Intensive Care Unit (PICU) TPNs (pharmacies should consider pre-making starter NICU and PICU TPNs during normal business hours to avoid delays in care)
Methotrexate for non-cancer use	Cardioplegic solutions
Cidofovir and Ganciclovir	
Amphotericin B (any form)	
Dialysis solutions, peritoneal and hemodialysis	
Nonstandard intravenous drip concentrations	

Navy Pharmacy SOP: Inpatient Pharmacy Operations

Potassium chloride or acetate for infusion (concentrations exceeding 10mEq/100ml, rate exceeding 10mEq/hour [20mEq/100ml, rate exceeding 20mEq/hour if central access verified], total doses exceeding 60 mEq/24 hours); continuous infusion fluids exceeding 40 mEq/liter (when not used as part of a P&T Committee approved protocol).	
Potassium phosphate for infusion (concentrations exceeding 7.5mmol/100ml, rate exceeding 7.5mmol/2 hours (30mmol/250ml rate exceeding 7.5mmol/hour if central access verified), total doses exceeding 45mmol/24 hours; continuous infusion fluids exceeding 20mmol/liter (when not used as part of a P&T Committee approved protocol).	
Doses of calcium gluconate above 2g or calcium chloride above 1g IV (when not used as part of a P&T Committee approved protocol).	
Sodium chloride injection above 0.9% or below 0.45% (when not used as part of a P&T Committee approved protocol).	

In all cases, a pharmacist must perform a retrospective check of the provider's orders upon commencing their next shift.

Note: This list does not apply to situations where a LIP controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status). The use of premade, ready-to-use medications should be maximized. The original components used to make medications that are compounded by a pharmacy technician must be verified by a second person prior to administration. A LIP or nurse with documented competencies must prospectively verify the bag and its contents and document review on the appropriate compounding documentation log.

Refer to [Appendix E – Pharmacy Forms and Templates](#) to access the Sterile Compounding Log and Non-Sterile Compounding Log. This log must be reviewed and cosigned by a pharmacist at the beginning of their shift.

Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.2.6 Enter Order into CHCS

All orders sent to the pharmacy must be documented in CHCS. If CHCS is inoperable, refer to [2.2.10 Inpatient Downtime Procedures](#).

The Order Enterer shall locate the patient's inpatient CHCS profile and follow the appropriate steps below, depending on whether or not the order is part of a CHCS Order Set.

- *CHCS Order Set:* CHCS Order Sets mirror physician order sheets for commonly performed procedures and treatment regimens. These Order Sets allow pharmacy staff to simply select those medications that have been ordered by a provider rather than manually entering each medication and dose. When applicable, pharmacy staff shall follow the Command-established naming convention when naming their CHCS Order Sets.

If the ordered medications are part of a CHCS Order Set, the Order Enterer shall review the template for completion and accuracy. If the Order Enterer is satisfied that the template is complete and accurate, they shall follow the steps below:

- ✓ Locate the order set in CHCS
- ✓ Select all of the ordered medications from the CHCS Order Set
- Review the order for any edits or changes from the standard template that have been made by the physician and make the necessary edits to the CHCS Order Set.
- *Non-CHCS Order Set:* If the ordered medications are not part of a CHCS Order Set, or the template is found to be incomplete or inaccurate, the Order Enterer creates a new order in the patient's inpatient CHCS profile. The following information must be included in the new order:
 - ✓ Medication name
 - ✓ Medication dose
 - ✓ Medication route
 - ✓ Dosage schedule or flow rate
 - ✓ Any additional comments provided by the prescribing physician

Note: When documenting comments in CHCS, pharmacy staff is encouraged to follow best practices that are outlined in Appendix F- Documenting CHCS Clinical Overrides.

Navy Pharmacy SOP: Inpatient Pharmacy Operations

The following orders require additional information, not listed above. The Order Enterer shall enter the appropriate information, if not already documented in the patient's profile.

- *Altered Intervals:* Medications to be given at non-routine intervals, such as every other day, must have an annotation (8 characters or less) in the dosage "PRESCRIPTION COMMENT" field. An example includes:

- Every Sunday: "q Sunday"

- *Chemotherapy/Anti-Neoplastic Orders:* For additional information related to chemotherapy/anti-neoplastic orders, see [Appendix A-Guidelines for Preparation, Handling and Disposal of Chemotherapy and Anti-Neoplastic Orders](#).

For chemotherapy/anti-neoplastic orders intended for non-oncological use, standard procedures within this Inpatient Section may be followed.

- *Electrolyte Orders:* The pharmacist will compare electrolyte orders against established clinical protocols. If any changes are made to the electrolyte order, the pharmacist will notify the provider and receive provider approval for the changes.
- *Pediatric Orders:* For all CHCS pediatric patient orders patient weight must be available to the pharmacist for use in calculating proper doses. Pediatric patients are defined as those patients 12 years of age and under. Medications will not be dispensed until patient weight is verified. Doses must be checked using available references and the provider must be notified if doses are not within acceptable limits.
- *Post-Operative (OP) Orders:* All patients who return to a patient care ward after a surgical procedure or under the care of an anesthesiologist must have their orders rewritten. All pre-operative orders will be discontinued unless included as a new order in the post-procedure orders.
- *PRN Orders:* Medications written to be dosed "when needed" are documented in CHCS as "PRN" in the "SCHEDULE" field. All PRN orders should include an indication for use when the drug has multiple indications. When multiple drugs are written PRN for the same indication, the order or a supporting protocol should clearly delineate the order of use for the medications.
- *Transfer of Ward (TOW):* All orders for patients transferred to a new ward must be reviewed and re-entered into CHCS. The pharmacy shall only accept re-written orders, and must not accept blanket reinstatement of previous orders (such as "resume all previous medications"). When a patient's level of care changes, all medications should be reviewed for appropriateness.

Refer to [2.1.3 Perform Profile Review](#) for further information on the procedures required for profile review.



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2.2.7 Review Clinical Warnings



[MM05.01.01/4](#)

CHCS conducts a drug warning check and verification against a patient's known allergies and current medication list. If a drug warning presents, the pharmacist may choose to override the warning.

When choosing to override a drug warning, the pharmacist must first determine if a drug warning override is clinically acceptable. Clinical warnings must be reviewed for all inpatient medication orders. Review of clinical warnings must include a drug warning review and a review of allergy, duplicate therapy, and drug class warnings.

- *Drug Warning Review:* The pharmacist must review severe drug interaction warnings and document this review in CHCS. Pharmacy technicians may only clear moderate drug interaction warnings. A verbal authorization by a pharmacist is sufficient to indicate review, but all reviews must be documented in CHCS by the reviewing pharmacy technician, including a notation in the "WARNING COMMENT" field as to which pharmacist performed the review.
- *Review of Allergy, Duplicate Therapy and Drug Class:* The pharmacist must review allergy, duplicate therapy, drug class, contraindications, and other warnings associated with the medication order. The pharmacist must review and clear all warnings before order entry is complete.
 - Duplicate therapy and drug class warnings will automatically appear in CHCS based on the patient's profile, outpatient CHCS profile, and any new medications entered in Essentris.
 - Allergy warnings will update based on previously entered CHCS allergies. The pharmacy will communicate with the ward to ensure that an explanation for every new allergy is entered. The pharmacist will use this explanation to determine if the allergy is "true" or the result of another reaction, such as a medication side effect.
- *CHCS Unavailable:* If CHCS is unavailable, pharmacy staff will contact the ward to ensure all allergies and possible drug interactions are accounted for in the absence of clinical system support.



[MM05.01.01/8](#)

[MM05.01.01/9](#)

If an override is not acceptable or there is concern about the order, pharmacy staff will contact the provider and/or nursing staff. Within CHCS, pharmacy staff will choose to deny the override and select the appropriate reason for denying the override.

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Communication of Allergy Information between Systems

Essentris receives allergy information from CHCS via an HL7 message and this functionality requires a “trigger.” Currently, that trigger is defined as a clinic (in the case of Essentris ED) or an inpatient admission in CHCS.

Data communication challenges exist for the documentation of allergies within CHCS, Armed Forces Health Longitudinal Technology Application (AHLTA) and Essentris. The following describes how allergy information is shared between these systems. This relationship is also illustrated in Figure 2.2.6-1:

- Additions in CHCS push to AHLTA.
- Additions, comments, and deletions in AHLTA push to CHCS.
- Comments and deletions in CHCS do not push to AHLTA (these deletions can be overwritten by AHLTA).
 - Note: Changes on the same line are considered a deletion.
- At time of trigger, CHCS pushes to Essentris.
- Additions, deletions, and modifications in Essentris do not push to AHLTA or CHCS.
- All modifications in AHLTA push to CHCS, with potential data communication complications.
 - If the NKDA box is checked in AHLTA and a NEW allergy is added within CHCS, the NEW allergy will crossover to AHLTA and remain, overriding AHLTA's NKDA selection (unchecking the NKDA box).
 - If a patient has allergies listed in AHLTA, the NDKA checkbox is grayed out and cannot be selected until all allergies are deleted in AHLTA.

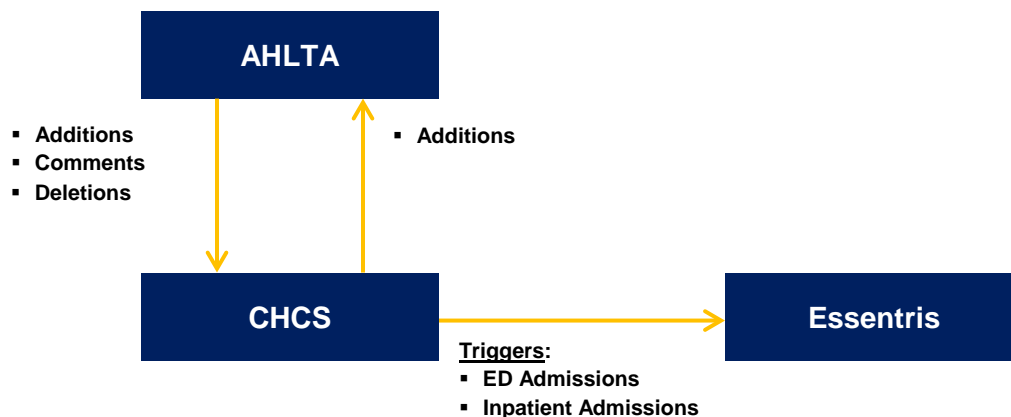


Figure 2.2.6-1: Communication of Allergy Information between Systems

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2.2.8 Review Order (LIP/Nurse)



In the absence of a pharmacist, a LIP or nurse with the appropriate documented competencies may perform pharmacist verification duties for inpatient orders.

[MM05.01.01/2](#)

[MM05.01.01/3](#)

[MM05.01.13/5](#)

A retrospective pharmacist review of nurse reviewed orders will occur at the beginning of the next shift. A retrospective review of LIP-reviewed orders should occur at the beginning of the shift as a best practice.

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2.2.9 Correct Order Errors and Perform Edits

If the Order Review process reveals the need for the pharmacy to correct an order error, the following steps shall be taken:

- *Pharmacy-Caught Clinical Error:* A pharmacist (or pharmacy technician when no pharmacist is present) must contact the provider and/or nursing staff for confirmation before making any clinical edits to an inpatient medication order, such as dosage edits. A pharmacist must perform or review the change to the order before submitting to the ward. Standard Essentris procedures for submitting changes shall be followed.
- *Pharmacy-Caught Non-Clinical Error:* When an edit that does not impact the clinical intent of the order is required, a pharmacist shall determine the required change and use his or her professional judgment to determine if contacting the provider is necessary to confirm the order edit. A pharmacy technician may contact the provider regarding the order edit, but a pharmacist must review the edit before administration to the patient.
- *PRN or "Take as Needed" Order:* For all order edits, the order must have specific instructions regarding purpose of use/schedule of administration. If it does not, the pharmacy will communicate with the provider to specify a schedule that includes a time interval at which the patient may take the medication, the required dosage and dosing schedule (which may not include double-ranges, e.g., "Take 1-2 pills 3-4 times daily") and an indication as to why the patient should take the medication.

For all order edits, the Order Reviewer must communicate with the provider and note the edit on the Essentris Status Board, or by or other suitable means. For wards without Essentris availability, all edits should be documented using a digital imaging device (such as PyxisConnect) or in different colored ink on the hard copy order.

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2.2.10 Inpatient Downtime Procedures

During facility downtime, Commands are expected to provide an appropriate level of care, as determined by Command capacity, patient population and the pharmacist's clinical and professional judgment. At a minimum, pharmacy staff will ensure that inpatient care continues, even during facility downtime.

Downtime situations may be the result of either scheduled or unscheduled downtime:

- *Scheduled Downtime:* Scheduled downtime is defined as downtime of one or more hospital information systems planned in advance for either routine maintenance or for an upgrade. Scheduled downtime normally occurs overnight, or at the end of the month, to minimize the interruptions to patient care and pharmacy workflow.
- *Unscheduled Downtime:* Unscheduled downtime is defined as unexpected downtime of one or more hospital information systems, due to equipment failure and/or network issues. Unscheduled downtime prevents operation of the standard pharmacy workflow and can impact patient care. Unscheduled downtime must be addressed to the appropriate personnel immediately.

Inpatient services downtime must be communicated to the appropriate individuals. If the downtime occurs during normal working hours, contact the Pharmacy Department Head or designee, as well as the Pharmacy System Manager or Medical Information Department (MID) to inform them of the downtime. If CHCS downtime occurs after normal working hours, contact the MID or the Officer of the Day.

In the event that downtime occurs, the following procedures must be followed:

- [ADC Downtime Procedures](#)
- [CHCS Downtime Procedures](#)
- [Essentris Downtime Procedures](#)

For additional information on downtime procedures, refer to [7.5 Continuity of Operations Plan \(COOP\)](#).

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ADC Downtime Procedures

When ADCs are non-operational, ward staff shall return operations to a unit dose delivery system until downtime ends.

Should it become necessary to manually open the ADC for patient medication access, the Pharmacy Department Head or designee must be notified. When authorized by the Department Head or designee, pharmacy staff may open the ADC to allow for the removal of patient medications.

CHCS Downtime Procedures

In preparation for scheduled CHCS downtime, the consolidated medication order list and batch labels must be double printed. All orders not added to the computer during downtime should be saved in a separate area and should have the number of doses sent indicated on the order. Additionally, pharmacy staff should keep ad hoc labels for unit dose and IV orders on hand to be used during scheduled and unscheduled CHCS downtime.

During CHCS downtime, the pharmacy will set ADCs to allow overrides of all medications from the ADCs in the ward, will enter orders directly into an ADC console, or will provide medications directly to the ward as directed by the Pharmacy Department Head. Once CHCS becomes operational again, the pharmacy will pull an override report and verify that the ward has entered an order for every medication pulled via override while CHCS was down.

The following steps shall be taken for order entry and processing:

- ✓ Update the last printed CHCS Unit Dose and IV Cart Lists as orders are manually received
- ✓ Pharmacy staff will contact the ward to ensure all allergies and possible drug interactions are accounted for in the absence of clinical system support.
- ✓ Separate orders by ward
- ✓ Deliver unit dose medications according to the standard delivery schedule
- ✓ Manually prepare all order labels to include the information detailed in [2.3.1 Prepare Inpatient Medication Labels](#)
- ✓ Record the outage in the Pharmacy Departmental Log, or a separate CHCS Downtime Log. The log entry must include the following information:
 - Time of the CHCS outage
 - Details related to CHCS outage
 - Last non-controlled, Schedule-II, and Schedule-III-V orders generated by CHCS

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Once the system returns to operation, orders must be entered into CHCS as soon as possible and checked by a pharmacist.

When CHCS is brought back online, the following information must be added to the log entry:

- ✓ Time that CHCS came back online
- ✓ Last non-controlled, Schedule-II, and Schedule-III-V orders processed during downtime

Essentris Downtime Procedures

During Essentris downtime, orders will be written on authorized forms (such as a SF508, Doctor's orders). A completed order must be written legibly in black ink and may be submitted in its original form or via fax or digital imaging device (such as PyxisConnect). All verbal orders must be taken by a pharmacist and written down immediately. Verbal orders will only be accepted during emergencies.

For safety during Essentris downtime, changes made to an order before being sent to the pharmacy should be made by making one line through the order with initials by the person changing the order. Changes made to an order after being sent to the pharmacy require a clarification/discontinued order on a separate line.

All orders must contain the information included under [2.2.4 Requirements for Order Entry](#).

If a medication order is incomplete, illegible, or unclear, pharmacy staff will contact either the provider or ward staff for clarification. The medication will not be dispensed until all questions regarding the order have been answered.

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2.3 Order Filling

Unit dose and IV medications are prepared and loaded in ADCs, such as Pyxis or Omnicell, or delivered to ward stock. Single orders are prepared for patient-specific medications and those not loaded in an ADC are stored in ward stock.

2.3.1 Prepare Inpatient Medication Labels

2.3.2 Prepare IV/Injectable Orders

2.3.3 Prepare Unit Dose Orders

2.3.4 Primary Review of Filling Calculations and Preparation

2.3.5 Missing Order Workload Capture

In accordance with current Joint Commission Medication Management Standards and National Patient Safety Goals, all prepared medication orders must be labeled per the requirements outlined in [2.3.1 Prepare Inpatient Medication Labels](#). Pharmacies are encouraged to use pre-printed labels to facilitate compliance with these requirements.

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Navy Pharmacy SOP: Inpatient Pharmacy Operations

2.3.1 Prepare Inpatient Medication Labels

All medications prepared for inpatient use must be labeled according to the following standards:

- [Patient-Specific Medications](#)
- [General Ward Stock Medications](#)
- [Additional Labeling Requirements](#)

Patient-Specific Medications

Inpatient medications prepared for patient-specific use must be labeled with the following information prior to distribution to the ward:

- ✓ Patient name
- ✓ Clear, concise directions for use
- ✓ Medication name
 1. Patient-specific medications will normally be labeled with the generic medication name; however the trade medication name may be used if the trade product is actually in the container.
- ✓ Dosage strength (in metric units)
- ✓ Beyond-use/expiration date, if applicable
 1. Beyond-use/expiration date may not exceed one year from the date of repackaging, or the manufacturer's original expiration date, whichever is less.
- ✓ Expiration time when expiration occurs in less than 24 hours
- ✓ Special storage requirements (i.e. refrigerate), if needed
- ✓ Administration instructions, if needed
- ✓ Proper auxiliary or cautionary labels as indicated

Patient location is printed automatically onto labels from CHCS. For information on labeling during CHCS downtime, refer to [2.2.10 Inpatient Downtime Procedures](#).

Additional labeling requirements for specific types of orders can be found in [Additional Labeling Requirements](#).



[MM03.01.01/7](#)
[MM05.01.09/2](#)
[MM05.01.09/3](#)
[MM05.01.09/4](#)
[MM05.01.09/5](#)
[MM05.01.09/7](#)
[MM05.01.09/8](#)
[MM05.01.09/9](#)
[MM05.01.09/10](#)
[MM05.01.09/11](#)
[MM05.01.09/12](#)

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General Ward Stock Medications

Non patient-specific medications issued to the ward (e.g., for placement in ADCs or crash cart trays), and not dispensed in the original container, must be labeled with the following information:

- ✓ Date of issue
- ✓ Generic medication name (preferred) or trade medication name (as needed for patient safety)
- ✓ Dosage strength
- ✓ Quantity to be dispensed
- ✓ Beyond-use/expiration date
 - Beyond-use date/expiration date may not exceed one year from the date of repackaging or the manufacturer's original expiration date, whichever is less.
- ✓ Expiration time when expiration occurs in less than 24 hours
- ✓ Special storage requirements (i.e. refrigerate), if needed
- ✓ Administration instructions, if needed
- ✓ Manufacturer name
- ✓ Lot number (or appropriate code)

Patient location is printed automatically onto labels from CHCS. For information on labeling during CHCS downtime, refer to [2.2.10 Inpatient Downtime Procedures](#).

Additional labeling requirements for specific types of orders can be found in [Additional Labeling Requirements](#).

Additional Labeling Requirements

In addition to the labeling requirements listed above, the following orders require further labeling procedures:

- *Chemotherapy/Anti-Neoplastic Orders:* For additional information related to labeling requirements for chemotherapy/anti-neoplastic orders, see [Appendix A-Guidelines for Preparation, Handling and Disposal of Chemotherapy and Anti-Neoplastic Orders](#).

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- *Compounded IVs:* All sterile compounded intravenous admixtures and parenteral nutrition formulas must include the date prepared and all active ingredients and final diluents. For further information on compounding operations, refer to [8.1.2 Prepare Sterile Compounded Medication](#).
- *Immediate Use:* Medications prepared for immediate use must be administered within one hour of their reconstitution and labeled according. Refer to [8.1.2 Prepare Sterile Compounded Medication](#) for additional guidance regarding the preparation of compounded sterile products (CSPs) designated for immediate use.
- *Inpatient Self-Care and Discharge Orders:* Self-care and discharge inpatient prescriptions should be labeled as outpatient prescriptions. Please refer to the outpatient labeling requirements in [3.3.4 Prepare Prescription Labels](#) for further information regarding the appropriate labeling of outpatient prescriptions.
- *Multiple Dose Vials (MDV):* IV orders in MDVs must be labeled with the following information:
 - Any opened or entered (e.g. needle punctured) MDVs must be labeled with the beyond-use date
 - MDVs with an antimicrobial preservative must be labeled with an expiration date of 28 days following the time of opening, unless otherwise specified by the manufacturer

Note: Pharmacy staff should procure and use single-dose vials (SDV) whenever possible; however, in the event that it is necessary to use MDVs (e.g., manufacturer shortage, logistical or clinical necessity), extra diligence need apply. Pharmaceuticals designed and designated for single patient use shall be labeled with specific patient information (e.g., insulin pens). For additional guidance from the Centers for Disease Control and Prevention (CDC) on MDVs, refer to the [CDC website](#).

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2.3.2 Prepare IV/Injectable Orders

Pharmacy staff will run a batch list at least once daily, and monitor new order submissions frequently, for IV and injectable orders. These orders will be delivered to the wards at a time and interval determined by the Pharmacy Department in collaboration with Nursing Services. The pharmacy will communicate with the wards to determine an appropriate medication delivery time.

When preparing IV and injectable orders, the following procedures should be completed:

- *Work Area and Personal Protection Preparation:* Each pharmacy that supports inpatient care shall have established procedures for personal gowning and workplace sterilization that comply with the intent of [United States Pharmacopeia \(USP\) 797 Guidelines: Pharmaceutical Compounding – Sterile Preparations](#) standards. For further information on USP 797 minimum requirements, refer to [8.1 Sterile Compounded Medication](#).
- *Preparation of Sterile Products:* Each pharmacy that supports inpatient care shall have established procedures for the preparation of materials for use in sterile products preparation. During preparation, pharmacy staff will visually inspect the medication for particulates, discoloration, or other loss of integrity.
- *IV Logbook:* Inpatient IV preparations shall be logged and tracked. For each new IV preparation, an entry must include:
 - ✓ Patient Name
 - ✓ Medication
 - ✓ Lot Number
 - ✓ The date and time of preparation
 - ✓ The filling pharmacy technician's name and/or number
 - ✓ The verifying pharmacist's initials and/or number

Separate logs must be kept for the following orders (see [Appendix E – Pharmacy Forms and Templates](#) for further information):

- Compounded IV or injectable orders
- Compounding lots assignments
- IV or injectable orders

Refer to [7.1.11 Lot Number Generation](#) for instructions on generating lot numbers.

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When preparing the following orders, see additional guidance below:

- [Chemotherapy/Anti-Neoplastic Orders](#)
- [Hazardous/Special Handling Orders](#)
- [Total Parenteral Nutrition \(TPN\) Orders](#)

Chemotherapy/Anti-Neoplastic Orders

Preparation of all chemotherapy/anti-neoplastic orders must comply with the intent of [USP 797](#) standards.

For additional information related to chemotherapy/anti-neoplastic orders, see [Appendix A- Guidelines for Preparation, Handling and Disposal of Chemotherapy and Anti-Neoplastic Orders](#). For chemotherapy/anti-neoplastic orders intended for non-oncological use, standard procedures within this Inpatient Section may be followed.

Hazardous/Special Handling Orders

Any drug considered hazardous and requiring special handling, as stated by its manufacturer, will be compounded in the chemo-isolator. The only exceptions to this rule would be any compound that would damage the internal Hepa filter due to its volatility. The Material Safety Data Sheet (MSDS) should be consulted if there is a question regarding any specific compound.

Any substance that could contaminate the work environment (e.g., autologous blood products) should not be prepared in a chemotherapy preparation hood. A fume hood is recommended for preparing non-sterile, volatile substances.

TPN Orders

When appropriate, the pharmacy will communicate with the ward to ascertain if the dietician has reviewed the Total Parenteral Nutrition (TPN) order before sending the order to the pharmacy. TPN orders must be re-written as new orders and dated appropriately prior to their submission to the pharmacy; furthermore, it is recommended that TPN orders also be reviewed by the dietician. The pharmacy will communicate with the ward regarding the appropriate time due for daily TPN order submission.

All preparations of TPN orders must be supervised directly by a pharmacist. No solutions should be added to one another until the pharmacist has visually verified the content (i.e., drawn syringes are verified by a pharmacist before admixing). Once the TPN order is prepared by either a pharmacist or a qualified technician, the TPN preparation, additives, and dosing calculations must be verified by a pharmacist.

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2.3.3 Prepare Unit Dose Orders



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Pharmacy staff will check for new unit dose orders daily. These orders will be delivered to the wards at a specific time every day and will contain 24 hours' worth of medication. The pharmacy will communicate with the wards to determine an appropriate medication delivery time.

When filling unit dose orders, the pharmacy staff shall remove the appropriate medication from the pharmacy stock and select the ordered dose. If the medication is not available in pre-packaged form, the pharmacy staff must package the dose using unit dose packaging materials. The order label is then affixed to the medication, and the order awaits final verification by a pharmacist.

Pharmacists will consult the clear compounding guidelines and pre-packing instructions for all compounded and prepackaged pharmaceuticals provided in the Draft DoD Compounding Pharmaceuticals Recipe Book, which can be accessed on the [Navy Pharmacy NKO Page](#). Pharmacy staff will also adhere to applicable USP [795](#) and [797](#) guidelines related to non-sterile and sterile compounding.

Should the preparation of unit dose orders require that the pharmacy compound a medication, this action will be recorded in a logbook (see [Appendix E – Pharmacy Forms and Templates](#) for further information). When assigning lot numbers to compounded medications, the lot numbers must also be recorded in a logbook (see [Appendix E – Pharmacy Forms and Templates](#) for further information). Refer to the [7.1.11 Lot Number Generation](#) for instructions on generating lot numbers.

See additional guidance below for preparing controlled substance orders.

Prepare Controlled Substance Orders and DHPDs

MTFs shall use the standardized dispense, main vault/breakout vault inventory, and requisition forms to audit and monitor Schedule-II medications, as well as locally-selected drugs with a high potential for diversion (DHPD) that the Command chooses to treat as Schedule-II medications, from receipt into inventory until dispensing. For sites using electronic inventory, staff should follow the instructions applicable to the system (e.g., CHCS).

If the pharmacy receives a controlled substance order for a medication that is not in their working stock, and the main narcotics vault is not operated within the pharmacy, they shall call, fax, electronically submit or deliver the order to the main narcotics vault for filling.

All Schedule-II orders, and orders for locally-selected DHPDs that the Command chooses to treat as Schedule-II medications, must be counted and back-counted against the stock bottle and verified against the appropriate inventory record. If a discrepancy arises that cannot be resolved within the pharmacy, pharmacy staff shall coordinate an investigation with the Controlled Substances Inventory Board (CSIB).

For additional information on inventorying controlled substances, refer to [9.0 Controlled Substance Operations](#). To access controlled substance forms, refer to [Appendix E – Pharmacy Forms and Templates](#).

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2.3.4 Primary Review of Filling Calculations and Preparation

All calculations and preparations must be reviewed by the Order Filler. This review is necessary to ensure that doses are accurately calculated and prepared. When available, at least one of the reviewers shall be a pharmacist. Acceptable secondary reviewers include:

- LIP/nurse with documented competencies
 - Refer to [2.2.8 Review Order \(LIP/Nurse\)](#) for further information on LIP/nurse order review.
- Pharmacist
- Pharmacy Technician

If a pharmacist is not the secondary reviewer, a pharmacist shall review as soon as possible during the next duty shift. Despite the lack of a requirement for pharmacist review of LIP-reviewed orders, a retrospective pharmacist review should be performed as a best practice.

Chemotherapy/Anti-Neoplastic Orders

Review of all preparations and calculations used for chemotherapy/anti-neoplastic orders must comply with the intent of [USP 797](#) standards.

For additional information related to chemotherapy/anti-neoplastic orders, see [Appendix A- Guidelines for Preparation, Handling and Disposal of Chemotherapy and Anti-Neoplastic Orders](#). For chemotherapy/anti-neoplastic orders intended for non-oncological use, standard Inpatient procedures may be followed.

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2.3.5 Missing Order Workload Capture

In cases in which a medication dose is lost or misplaced, the inpatient pharmacy must take specific procedures when replacing the medication in order to properly record Medical Expense and Performance Reporting System ([MEPRS](#)) workload credit. The pharmacy shall not reprint the missing medication label, as no new workload credit is captured.

These procedures will also be followed in cases in which the pharmacy is given the patient's outpatient label:

- *Missing Order Workload Capture (for non-Schedule-II Medication Orders):* The pharmacy shall utilize the CHCS function for Extra Unit Dose (EUD) to prepare an additional unit dose order and print the label accordingly. EUD allows workload credit to be captured for both the missing order and the replacement order.
- *Missing Order Workload Capture (for non-Schedule-II intravenous drip, intravenous piggyback (e.g., compounded IVs), or intravenous fluid (e.g., normal saline orders)):* The pharmacy shall utilize CHCS to create a new one-time order and print the label accordingly. Workload credit will be captured for both the missing order and the replacement order.
- *Missing Order Workload Capture (for Schedule-II Medication Orders, unit dose and IV):* The standard discrepancy resolution procedures shall be followed. If the discrepancy cannot be immediately resolved, and a replacement order is required, the pharmacy must cancel the initial order and reissue a new order to ensure proper inventory of Schedule-II medications.

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2.4 Order Final Verification

All prepared orders receive final review and verification before delivery to the ward. All required order information, patient information, and preparation materials must be reviewed before administration.

2.4.1 Final Order Verification—Verify Order Information

2.4.2 Verify Preparation Materials

2.4.3 Verify Preparation Calculations

2.4.4 Verify Final Product

2.4.5 Additional Verification Processes

2.4.6 Correct Order Errors and Perform Edits

2.4.7 Verify Order (Pharmacy Technician)

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2.4.1 Final Order Verification — Verify Order Information

All new pharmacy-prepared inpatient orders must include the following:

- ✓ Two Patient Identifiers:
 1. Name AND
 2. Date of Birth OR Department of Defense (DoD) identification number OR social security number
- ✓ Date/time written
- ✓ Generic name of the medication
- ✓ Form of the medication
- ✓ Dosage size or strength (in metric units)
- ✓ Dosing schedule
 - Dosing schedule may not include double ranges (an example of a double-range dosing schedule is: “Take 1-2 pills 3-4 times daily”)
- ✓ Patient weight in kilograms (for pediatric patients age 12 and under, and weight-specific medications)
- ✓ Patient allergies
- ✓ Provider name
- ✓ Provider initials (in Essentris) OR signature (hard copy orders)



[MM04.01.01/5](#)

[MM04.01.01/6](#)

If an order is incomplete or unclear, pharmacy staff must contact the provider or ward staff for clarification. The medication will not be dispensed or available in the ADC until all questions regarding the order have been answered. All verbal orders given by the provider must be taken by a pharmacist and written down immediately in Essentris. Verbal orders are not routine and read back is required.

All orders must be reviewed by a pharmacist either before or after preparation, as determined by the class, type, and level of risk associated with the medication.

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“Must Contact Pharmacist” List

For final verification procedures of medications and medication classes in the Must Contact Pharmacist list refer to [2.2.5 Must Contact Pharmacist List](#).

2.4.2 Verify Preparation Materials

A pharmacist must retrospectively verify any materials used during the order preparation. At a minimum the pharmacist must check the following:

- ✓ Source product(s) are not expired
- ✓ Appropriate products and concentrations were used
- ✓ For IV orders, materials are logged in the IV or Injectable Orders Log (See Appendix E – Pharmacy Forms and Templates for additional information regarding the IV Log)
- ✓ Materials for product preparation and container transfer (filters, filter needles for ampoules)

2.4.3 Verify Preparation Calculations

A pharmacist must retrospectively verify any dosing calculations performed during order preparation. At a minimum the pharmacist must check the following:

- ✓ Volumes used of each component
- ✓ Concentrations of reconstituted vials
- ✓ Concentrations of final admixtures
- ✓ Rates of administration

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2.4.4 Verify Final Product

All products must be reviewed by a pharmacist or by an LIP/Nurse with documented competencies if a pharmacist is not present, before dispensing. In addition to verifying the order, materials and calculations, prior to dispensing, at a minimum, the pharmacist must check the following:

- ✓ The final product is reconciled with the provider's orders
- ✓ The package shows no evidence of leaking or physical damage
- ✓ Product shows no signs of particulates, discoloration or other loss of integrity
- ✓ Medications are labeled according to the information found in [2.3.1 Prepare Inpatient Medication Labels](#).
- ✓ The product came from the appropriate stock container if the product is not labeled as a unit dose by the manufacturer

If the pharmacist cannot verify the prescription prior to dispensing, a pharmacist must retrospectively verify actual product used during order preparation, other materials and calculations. The technician can document the products used by recording the lot number and manufacturer of the product as well as saving the materials and/or making a photocopy of the materials and product being dispensed.

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2.4.5 Additional Verification Processes

In addition to the procedures listed above, the following orders have specific verification processes associated with them:

- *Verify Chemotherapy/Anti-Neoplastic Orders:* A pharmacist must verify that labs were reviewed and that the order is appropriate for administration to the patient. Verification of all chemotherapy/anti-neoplastic orders must comply with [USP 797](#) standards.
- For additional information related to chemotherapy/anti-neoplastic orders, see [Appendix A-Guidelines for Preparation, Handling and Disposal of Chemotherapy and Anti-Neoplastic Orders](#). For chemotherapy/anti-neoplastic orders intended for non-oncological use, standard procedures within this Inpatient Section may be followed.
- *Verify Controlled Substance Orders:* A pharmacist must indicate controlled substance order verification (Schedule-II-V medications and locally-selected DHPDs that the Command chooses to treat as Schedule-II medications) by signing the medication label.
- *Verify Electrolyte Orders:* The pharmacist will compare electrolyte orders against established clinical protocols. If any changes are made to the electrolyte order, the pharmacist will notify the provider and discuss any potential changes.
- *Verify Injectable Orders:* A pharmacist must verify that pre-filled injectables (such as syringes or cartridges) contain:
 - A medication volume that is consistent with the labeled fill volume and that they are not overfilled
 - A medication concentration that is consistent with the labeled concentration
- *Verify Override Orders:* In cases in which an override order has been distributed to a patient, the ward staff will enter the order into Essentris after it has been administered to the patient. A pharmacist will review the order retrospectively and ensure that it is entered into CHCS, incorporating the order into the patient's inpatient profile.

An override report will be generated daily, listing all medications that have been pulled via override. The pharmacist will compare the override report to patients' CHCS profiles to confirm that no discrepancies have occurred. If discrepancies are found, the pharmacist will communicate with the ward to have the missing orders entered in Essentris, or faxed or delivered to the pharmacy. All override reports must be kept on file for a minimum of 30 days.

- *Verify TPN Orders:* After a TPN order is filled, a pharmacist must again verify all TPN preparation, additives, and dosing calculations to determine if the order is appropriate for administration to the patient.

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2.4.6 Correct Order Errors and Perform Edits

If the Order Final Verification process reveals the need for the pharmacy to correct an order error, the following steps shall be taken:

- *Pharmacy-Caught Clinical Error:* A pharmacist or pharmacy technician must contact the provider and/or nursing staff for confirmation before making any clinical edits to an inpatient medication order, such as dosage edits. A pharmacist must perform or review the change to the order before submitting to the ward. During hours without pharmacist coverage, all order changes or clarifications must be completed by the provider. Standard Essentris procedures for submitting changes shall be followed.
- *Pharmacy-Caught Non-Clinical Error:* When an edit that does not impact the clinical intent of the order is required, a pharmacist shall determine the required change and use his or her professional judgment to determine if contacting the provider is necessary to confirm the order edit. A pharmacy technician may contact the provider regarding the order edit, but a pharmacist must review the edit before administration to the patient.
- *PRN or "Take as Needed" Order:* When a PRN order is received, the order must come with specific instructions regarding purpose of use/schedule of administration. If it does not, the pharmacy will communicate with the provider to specify a schedule which includes a time at which the patient may take the medication, the required dosage and dosing schedule (which may not include double-ranges, e.g., take 1-2 pills 3-4 times daily), and an indication as to why the patient should take the medication.

For all medication order changes, the edit must be documented in the medication order through Essentris. For wards without Essentris availability, all edits should be documented using a digital imaging device (such as PyxisConnect) or in different colored ink on the hard copy order.

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2.4.7 Verify Order (Pharmacy Technician)

In cases in which a pharmacist is not available to review an inpatient medication order and technician verification must be performed, pharmacy technicians must follow a standard checklist for order review. Each inpatient medication order must be reviewed by one of the following before dispensing to a patient:

1. LIP with documented competencies.
2. Nurse with documented competencies.
 - Refer to [2.2.8 Review Order \(LIP/Nurse\)](#) for further information on LIP/nurse order review.

When available, a second pharmacy technician must review the order before the LIP, nurse, or night duty on-call pharmacist.



Inpatient pharmacies without a staffed night pharmacist shall follow the standard process to ensure proper verification of medications before administration:

- ✓ Pharmacy technicians shall consult a standard “must contact-pharmacist” list before dispensing an order.
- ✓ A night-duty cell phone or pager shall be issued to a pharmacist for a read-back review of the technician-reviewed order for medications or medication classes in the Must Contact Pharmacist List (refer to [2.2.5 Must Contact Pharmacist List](#) for additional information).
- ✓ In cases when the night-duty pharmacist is unavailable, inpatient orders must be retrospectively checked by a pharmacist during the next shift in which a pharmacist is on duty. The pharmacist will check both the order and staging of the order. All orders must be checked at the beginning of the next shift.

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2.5 Ward Stocking



Stock medications including ADC medications, cart stock medications, and crash cart medications, are prepared, verified, and issued to wards. The pharmacy shall utilize managed processes (such as clinic and ward ADS or locked boxes and cabinets with a manual setting) to prevent unauthorized individuals from obtaining medications in accordance with Command policy, state law, and additional regulation as appropriate.

2.5.1 [Stock ADC Medication](#)

2.5.2 [Stock Unit Dose Cart Medication](#)

2.5.3 [Stock Crash Cart Trays](#)

2.5.4 [Stock Controlled Substance Medication](#)

2.5.5 [Perform Discrepancy Resolution](#)

2.5.6 [Return Inpatient Medications to Pharmacy](#)

2.5.7 [Discharge Medications](#)

2.5.8 [Ward/Clinic Inspections](#)

To return to the Table of Contents, click [here](#).

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2.5.1 Stock ADC Medication

Replenishment of the ADC will be the responsibility of the pharmacy. A refill report will be generated, at a frequency determined by the Pharmacy Department, to identify medications that have depleted below minimum stock levels and need to be refilled. The pharmacy will refill each ADC based on the refill report.

Refer to [7.4 Automated Dispensing Cabinets \(ADCs\)](#) for further information regarding stocking ADC medication.

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2.5.2 Stock Unit Dose Cart Medication

Medications not stocked in ADCs are stocked in unit dose carts or other patient-specific bins for ward staff administration to patients. Pharmacy staff shall refresh the unit dose carts or patient-specific bins every 24 hours, at a consistent time. Throughout this process, the unit dose carts or patient-specific bins must be secured such that non-authorized personnel do not have access.

Pharmacy staff shall consult the Medication Administration Record (MAR) to determine the medications needed to stock the unit dose cart or other patient-specific bins. To receive workload credit for preparing this medication stock, the pharmacy staff must print a Daily Unit Dose Cart List. This list is printed in CHCS using the following menu path:

- ✓ Pharmacy System Menu > Unit Dose Menu > Dispensing Menu > Print Cart List or ^CAR

The Unit Dose Cart List should be printed at the same time daily and filed within the pharmacy for use in case of CHCS/ADC downtime, and may also be used to stock unit dose carts or other patient-specific bins for ward administration to patients.

Medications for each patient will be stocked in that patient's specific area of the unit dose cart or patient-specific bin. The patient area must be labeled with the following minimum patient-specific information:

- ✓ Patient's first and last name
- ✓ A second patient identifier
- ✓ Allergies

All medications stocked in the unit dose cart or patient-specific bin shall be labeled according to the information found in [2.3.1 Prepare Inpatient Medication Labels](#).

Upon stocking and before returning to the ward, a pharmacist will review the contents of the unit dose cart or patient-specific bins, and acknowledge the review on the pharmacy Unit Dose Cart List. The pharmacy staff will then coordinate with ward staff to return the medications to the ward. A member of the ward staff must review the unit dose cart or patient-specific bin contents and acknowledge this review, as well as receipt of the unit dose cart or patient-specific bin, on the pharmacy Unit Dose Cart List.

The Unit Dose Cart List will be filed in the pharmacy for a period of 30 days after documenting pharmacist verification and unit dose cart or patient-specific bin delivery to the ward.

Note: Pharmacies with ADCs may use an ADC-generated list that specifies which medications are not stocked within the ADC, rather than the Unit Dose Cart List to stock the unit dose cart or patient-specific bins. However, the Unit Dose Cart List should still be printed to gain workload credit and as a back-up in the event of CHCS/ADC downtime.

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2.5.3 Stock Crash Cart Trays



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[MM03.01.03/2](#)

[MM03.01.03/3](#)

[MM03.01.03/6](#)

Pharmacies shall utilize a standard process for inventorying, replenishing, and verifying crash cart trays. A pharmacist must prospectively review all crash cart trays before they are issued to a ward/clinic.

The local P&T Committee (or appropriate local committee with control over emergency medications), based on current therapy guidelines, will determine which emergency medications are stored in crash carts and where these crash carts are located. These medications will be of immediate use or in unit dose packaging whenever possible.

Before issuing a new crash cart tray to the ward/clinic staff, the Ward Stocker must document that a crash cart tray has been “checked-out.” The pharmacy must maintain a logbook of all crash cart tray transactions. See [Appendix E – Pharmacy Forms and Templates](#) for additional information regarding the crash cart tray dispensing log.

The following steps must be taken by the pharmacy to replenish a crash cart tray:

Types of crash cart trays may include:

- Adult
- Pediatric
- Infant

- ✓ *Examine crash cart tray medication quantities:* Different medication quantities and dosages are required depending on the type of crash cart tray. The pharmacy shall have an established list for each of these crash cart trays for use in determining the appropriate restocking amount. The quantity of these crash cart trays will vary, as determined by patient need.
- ✓ *Examine crash cart tray expiration dates:* All short-dated medications should be removed from the crash cart tray and returned to pharmacy inventory. Pharmacy shall use clinical judgment to determine which medications must be removed (depending on the medication, the expiration date will be within 30-90 days).
- ✓ *Document crash cart tray inventory:* After restocking the medications, the pharmacist or pharmacy technician must document the crash cart tray inventory using a paper record. One copy of this record must be kept in the crash cart tray, and a second copy maintained on file. See [Appendix E – Pharmacy Forms and Templates](#) for additional information on this crash cart tray inventory record.

Upon stocking, a pharmacist will review the contents of the crash cart tray and acknowledge the review on the pharmacy crash cart tray inventory record. Upon pharmacist verification, and before storage or distribution to ward/clinic staff, the following crash cart tray procedures must be followed:

- ✓ Crash cart tray must be sealed with a specific identification number (a broken seal will signal unauthorized access to the crash cart medication).
- ✓ The specific identification number must be documented in a crash cart tray tag log. See [Appendix E – Pharmacy Forms and Templates](#) for further information on the crash cart tray tag log.

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- ✓ Crash cart tray must be labeled with the type of cart (e.g., adult, pediatric, infant) and the crash cart tray expiration date. The tray expiration date is the earliest expiration date of any product in the crash cart tray.
- ✓ Crash cart inventory record must be verified by the pharmacist. One copy will go in the crash cart tray and one copy will be filed in the pharmacy. See [Appendix E – Pharmacy Forms and Templates](#) for further information on the crash cart tray inventory record.
- ✓ Medications are labeled according to the information found in [2.3.1 Prepare Inpatient Medication Labels](#).

Additionally, the pharmacy must monitor and record the distribution of crash cart trays. See [Appendix E – Pharmacy Forms and Templates](#) for further information on the requirements for logging the distribution of crash cart trays.

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2.5.4 Stock Controlled Substance Medication

Pharmacy staff will deliver orders for Schedule-II medications, and locally-selected DHPDs that the Command chooses to treat as Schedule-II medications, to the ward along with the requisite NAVMED 6710/1. The pharmacy staff member that delivers the order must sign the NAVMED 6710/1 to acknowledge its delivery to the ward. The member of the ward staff that receives the controlled substance order must sign the NAVMED 6710/1 form to acknowledge receipt of the order and record the time the order was received. The NAVMED 6710/1 form will then be returned to the inpatient pharmacy to be filed for a period of two years.

- If the pharmacy elects to use CHCS to inventory Schedule-II and locally-selected DHPDs, staff should follow the electronic inventory instructions provided in the CHCS vault functions.

For additional information on inventorying controlled substances, refer to [9.0 Controlled Substances Operations](#). To access controlled substance forms, refer to [Appendix E – Pharmacy Forms and Templates](#).

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2.5.5 Perform Discrepancy Resolution

All discrepancies should be resolved as soon as possible to avert problems during the evening and night shifts. Discrepancies that cannot be resolved shall be managed by the ward staff. Pharmacy staff shall cooperate with the ward during any discrepancy resolution process or investigation.

- *ADCs:* When medications taken from the ADCs are missing, dropped, or contaminated, ward staff should:
 - ✓ Contact the pharmacy if unable to remove additional dose due to automated dispensing cabinet device settings
 - ✓ Request that a new supply be sent to the floor

Before sending the medication, pharmacy personnel will verify that the medication (and all requisite information) is in the patient's profile. If it is not in the profile, the ward must re-submit the order before the medication is sent.

- *Schedule-II Medications:* When a Schedule-II medication discrepancy occurs on a ward, the ward staff is responsible for investigating and resolving the discrepancy. If a discrepancy cannot be resolved, pharmacy personnel (including the vault technician) shall coordinate with the investigation and report any unresolved narcotic inventory discrepancies to the senior member of the Controlled Substances Inventory Board CSIB or appropriate higher authority.

2.5.6 Return Inpatient Medications to Pharmacy

Certain inventory, reverse distribution, or wasting procedures must be followed for medications returned from inpatient care areas upon patient discharge.

- *Unit Dose Cart or Patient Specific Bins:* Medication carts and bins should be inspected as part of drug utilization review. Unit dose carts returned to the pharmacy should contain only PRN (dosed as needed) medications, discontinued, or unused medications. All scheduled medications returns should prompt a review to determine why the patient did not receive the intended medication.

For information regarding inventory and reverse distribution procedures, refer to [6.2 Manage PVP Returns and Credits](#). For information regarding wasting medications, refer to [7.7.7 Disposal of Pharmaceutical Waste](#).



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2.5.7 Discharge Medications

When a patient is determined to be ready for discharge, the provider will annotate in Essentris as to which medications should be continued, via the Essentris Discharge Summary Note (or by or other suitable means). All discharge medications shall be prepared according to the procedures found in [3.2 Prescription Entering and Processing](#).

Note: It is the responsibility of the nursing staff to ensure that pharmacy staff is notified regarding patient discharge orders.

When clinically acceptable, the pharmacy will take steps to facilitate sending discharged patients home with their unused inpatient medications (e.g., inhalers, topicals) to eliminate the unnecessary waste of disposing of these medications in the pharmacy. All medications dispensed in this manner must be labeled according to labeling requirements for outpatient prescriptions found in [3.3.4 Prepare Prescription Labels](#).

The Pharmacy Department Head is responsible for ensuring that the Command policy on discharge procedures is provided. Please embed your Command policy below.

2.5.8 Ward/Clinic Inspections

Pharmacy staff shall conduct ward and clinic inspections on a monthly basis, at minimum. Results of this inspection will be recorded using a Ward Inspection Record. If discrepancies are found in the ward stock, the pharmacy staff shall notify the ward supervisor so that corrective action can be taken.

For additional information on ward inspections, refer to [7.8.2 Ward and Clinic Inspections](#). To access the appropriate inspection forms, refer to [Appendix E – Pharmacy Forms and Templates](#).

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3.0 OUTPATIENT PHARMACY OPERATIONS

The procedures stated within this Section of the Navy Pharmacy Standard Operating Procedure (SOP) apply to outpatient pharmacy operations.

Five Critical Duties exist related to outpatient pharmacy operations:

3.1 [Patient Check-In](#)

3.2 [Prescription Entering and Processing](#)

3.3 [Prescription Filling](#)

3.4 [Prescription Final Verification](#)

3.5 [Prescription Dispensing](#)

If utilizing Telepharmacy technology, refer to [4.0 Telepharmacy Operations](#).

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3.1 Patient Check-In

All patients are required to check-in to the outpatient pharmacy when picking up an outpatient prescription. Pharmacy staff shall confirm patient eligibility and verify basic patient health information with every patient visit.

3.1.1 Patient Queuing

3.1.2 Patient Identification

3.1.3 Patient Eligibility

3.1.4 Patient Prescriptions

3.1.5 Patient Allergies

3.1.6 Patient Weight

3.1.7 Perform Pregnancy/Lactation Query

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3.1.1 Patient Queuing

Patient queuing systems manage pharmacy workflow and prioritize patients by status or medical necessity. If the pharmacy operates a patient queuing system (i.e., Q-Matic, QFlow) the following guidelines apply:

- Check-in kiosk or equivalent tool is easily visible and accessible to all patients.
 - Patient check-in kiosks should be placed in a location that maximizes visibility for patients entering the pharmacy, while also protecting patient privacy (i.e. not directly next to pharmacy service windows).
- Instructions for using the check-in kiosk or equivalent tool are clear and concise.
- Patients are categorized within the queuing system using queuing rules that meet the pharmacy's scope of services and patient population.
 - Queuing rules normally have multiple ticket priorities designated by letter. When scope of services and patient population allow, emergency room patients, active duty patients in uniform or on work status, and discharge patients shall be prioritized ahead of all other patients. Examples may include:
 - "A" ticket- Active Duty in Uniform / Staff Member on Duty
 - "B" ticket- Retiree / Dependent / Active Duty Not in Uniform
 - "D" ticket - Discharged from NH [site name] Inpatient Stay or Post Surgery / Operation
 - "E" ticket - [site name] Emergency Room Prescription(s)
 - "R" ticket- Refill pickup (Already called into [insert local refill phone # here] at least [insert site turnaround time] hours ago)
 - Additional queuing categories may be added as needed to meet local needs (i.e. Wounded Warriors)
 - Some tickets may have equal priority, (i.e. A, D, and E tickets may all have equally weighted priority), but are separated for readability purposes
 - Every effort shall be made to maintain continuity of service for all other patients to mitigate disproportionate wait times.
 - Note: The capability exists within queuing systems to update the queuing rules to maintain continuity of service. For example, a pharmacy can update queuing rules so that a mass arrival of Active Duty in Uniform does not absorb all available service points. Examples of standard rules may include:

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- “R” tickets directed to a specific refill pickup window
- A weighted formula to ensure that “A” ticket wait time is equal to 50% that of “B” tickets

OR

- Four “A” tickets are called for one “B” ticket (80%)
- The queuing rules should also include thresholds for when a deviation from the standard rules should be used. These are generally determined by wait time such as:
 - If an “A” ticket wait time is greater than 15 minutes, they may be called 100% until the discrepancy is resolved.
 - If a “B” ticket wait time is greater than 40 minutes, they may be called 100% until the discrepancy is resolved.
- Note: The ideal set of queuing rules balances priority for Active Duty personnel with our commitment to all beneficiaries.
- Pharmacy staff shall use professional judgment to determine when it is appropriate to deviate from the standard pharmacy queuing process for high priority patients (e.g., patients whose ailments have a negative impact on those present in the waiting room). Any pharmacy staff member is empowered to utilize this deviation when warranted.
- Queuing tickets clearly state the patient’s queuing number.
- Queuing ticket numbers are audible and/or clearly visible when called to allow the patient to easily identify which window to approach.

Patients that pull an incorrect ticket (e.g., a ticket for the wrong patient category) should not be required to pull another ticket. Instead, pharmacy staff should explain the ticket procedure and incorporate the patient into the correct queue. Patients shall receive credit for time waited.

The pharmacy shall establish procedures for identifying patients who have missed their queuing number. Examples of such procedures can include communicating missed queuing numbers to the patients in the waiting room and accommodating those patients who have missed their queuing number. At a minimum, the following procedures shall be followed:

- ✓ Patients shall be given sufficient time to approach the window.
 - Consider calling tickets multiple times or displaying numbers that have been called.

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- ✓ Consideration should be given to the site's ability to communicate missed ticket numbers to patients in the waiting room.
- ✓ If a patient with a missed ticket approaches the window, the ticket shall be prioritized if the ticket is within 10 numbers of the most current ticket being served. Pharmacy staff may use professional judgment to award credit for time already waited when integrating the patient with the missed ticket into the queue.

Note: Sites utilizing QFlow may move the appropriate ticket from the “Abandon Queue” to the “Next Available Queue” to await dispensing.

If a queuing system is not used in the outpatient pharmacy, the pharmacy shall take steps to make all patients aware of the specific queuing process used by the pharmacy.

Pharmacy staff shall address all patients in a professional manner and with the use of a title (e.g., Mr., Ms.). Pharmacy staff shall also make every effort to address all active duty and retiree beneficiaries by rank when serving the patient at the pharmacy window.

A patient's rank can be found in the Composite Health Care System (CHCS) “NAME SEARCH” results.

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3.1.2 Patient Identification

Before a prescription can be filled, patient eligibility shall be confirmed and basic health information shall be verified. Pharmacy staff shall verify patient identification according to the following guidelines.

Note: Foreign nationals who fall within the Command's scope of services and present to pick up a prescription without appropriate identification should be directed to the facility's patient administration office to obtain a valid form of ID prior to returning to the pharmacy.

Patient Self Pick-Up

In accordance with Joint Commission National Patient Safety Goals, each patient shall provide the following two identifiers when picking up a personal prescription:

1. **First Patient Identifier:** Patient's name, as displayed on a valid, government-issued picture ID. Accepted forms of identification include a valid U.S. Uniformed Services ID card OR valid Common Access Card (CAC).

Note: Pharmacy personnel are empowered to use professional judgment to make exceptions for a patient who forgets to bring his or her valid, government-issued picture ID. If the patient is able to provide other identifying information, pharmacy personnel can use good judgment to authorize an exception. Pharmacy personnel can use this opportunity to educate about the patient about bringing his or her valid, government-issued picture ID to future visits.

2. **Second Patient Identifier:** Patient's date of birth, as recorded in his or her CHCS profile (preferred) OR social security number (SSN) OR U.S. Department of Defense (DoD) identification number.

Note: As part of the patient identification process, pharmacy staff must confirm that the patient is of an appropriate age to pick-up a personal prescription, in accordance with state law. For Outside the Contiguous United States (OCONUS) Military Treatment Facilities (MTFs), refer to the [Informed Consent for Medical and Dental Treatment Instruction \(BUMEDINST 6320.16\)](#).

The cardholder may allow photocopying of their ID card to facilitate DoD benefits. Refer to the [Identification Cards for Members of the Uniformed Services, their Eligible Family Members, and Other Eligible Personnel \(Section 1.8.1.1 of BUPERSINST 1750.10C\)](#) for additional information.

If applicable, the Pharmacy Department Head is responsible for ensuring that the Command policy on the appropriate age to pick up a personal prescription is provided. Please embed your Command policy below.

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Patient Pick-Up for Other Beneficiary

In accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations, agents of the patient (e.g., relatives, friends) may pick up prescriptions on the patient's behalf when the patient's agent can demonstrate BOTH:

1. Accurate identification of the patient using a minimum of 2 identifiers. The person presenting to collect the medication must prove the identity of the patient by providing one of the following in addition to the second identifier as noted above:
 - Patient's valid U.S. Uniformed Services ID or CAC OR
 - Front and back copy of valid U.S. Uniformed Services ID or CAC OR
 - Power of attorney
2. Accurate identification of the following:
 - Specific medication(s) OR
 - Type(s) of medication (e.g., pain medication, antibiotic, cold meds, birth control pills)

Note: Pharmacy personnel are empowered to use professional judgment to make exceptions for a patient who forgets to bring or does not have a photocopy or electronic copy of the other beneficiary's valid government-issued identification card. If the patient is able to provide other identifying information, pharmacy personnel can use good judgment to authorize an exception.

Pharmacies may implement additional measures to facilitate pick-up by a patient's agent (i.e., a locally developed form, signed by the patient to authorize another person to pick up prescriptions). However, additional measures should not result in barriers to care when the patient's agent can satisfy both above HIPAA related requirements.

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3.1.3 Patient Eligibility

Eligibility for pharmacy benefits shall be confirmed by inspecting the reverse side of a valid U.S. Uniformed Services ID card OR valid CAC.

Note: Reservists must present orders or other proof of pharmacy benefit eligibility.

Pharmacy staff must perform a Defense Eligibility Enrollment Reporting System (DEERS) check for all patients presenting a valid Veterans Identification Card (VIC) in lieu of a U.S. Uniformed Services ID or CAC. Pharmacies may choose to perform DEERS checks through CHCS or alternative methods on a case-by-case basis, such as by using the General Inquiry for DEERS ([GIQD](#)) system.

CHCS Menu Path for DEERS Check

- ✓ Select “OPM”
- ✓ Select a site
- ✓ Select “PDM”
- ✓ Select “DEC”

Exceptions for determining patient eligibility may be made, based on the pharmacist’s clinical and professional judgment. Exceptions may include specific procedures to verify eligibility for discharge patients or deploying contractors. Pharmacy staff shall contact their local patient administration department for additional guidance as needed.

Pharmacy staff should not be required to verify or collect Other Health Insurance (OHI).

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3.1.4 Patient Prescriptions

Pharmacy staff must verify with the patient the name(s) and total number of prescriptions the patient is picking up at the pharmacy.

If any prescriptions do not appear in CHCS, the patient shall not be required to restart the queuing process. Rather, pharmacy staff will:

- ✓ Determine how long it has been since the patient concluded their appointment.
 - The provider must complete the patient's Armed Forces Health Longitudinal Technology Application (AHLTA) medication record before prescriptions are available to the pharmacy.
- ✓ If sufficient time has passed since the patient's appointment, contact the provider to inquire about the prescription.
 - If pharmacy staff is unable to contact the provider, they will provide the patient with the option of returning to the clinic to request a re-submission of their prescription OR asking the pharmacy to continue to contact the provider and returning at a later time to collect their prescription.

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3.1.5 Patient Allergies

The pharmacy staff shall verify allergy information with patients for documentation in CHCS. Sites are encouraged to use AHLTA for allergy updates. When verifying patient allergies pharmacy staff shall follow the subsequent procedures:

- *No Known Allergy Documentation:* When a patient indicates that he or she has no known allergies, the pharmacy staff shall enter “NKDA” in the “ALLERGY” field of CHCS.
- *Patient Allergy Documentation:* When a patient indicates that he or she has known allergies, pharmacy staff shall document all allergies in the “ALLERGY” field of CHCS, and provide an explanation for every new allergy they enter in the associated “ALLERGY COMMENT” field below the selected allergy. The pharmacist will use this explanation to determine if the allergy is “true” or the result of another reaction (e.g., medication side effect).

If a patient indicates that he or she has known allergies to a combination medication (e.g., Percocet), pharmacy staff will indicate in the associated “ALLERGY COMMENT” field which medication is the cause of the allergy and which medication is tolerated, if it can be determined.

If the pharmacy does not have AHLTA access, pharmacy staff shall contact the clinic to request any changes to the allergies documented in the patient's profile. Additions to the patient's allergy profile will transfer from CHCS to AHLTA.

Data migration challenges exist for the documentation of allergies within CHCS, Armed Forces Health Longitudinal Technology Application (AHLTA) and Essentris. The following describes how allergy information is shared between these systems. This relationship is also illustrated in Figure 3.1.5-1:

- Additions in CHCS push to AHLTA.
- Additions, comments, and deletions in AHLTA push to CHCS.
- Comments and deletions in CHCS do not push to AHLTA (these deletions can be overwritten by AHLTA).
 - Note: Changes on the same line are considered a deletion.
- At time of trigger, CHCS pushes to Essentris.
- Additions, deletions, and modifications in Essentris do not push to AHLTA or CHCS.

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- All modifications in AHLTA push to CHCS, with potential data communication complications.
 - If the NKDA box is checked in AHLTA and a NEW allergy is added within CHCS, the NEW allergy will crossover to AHLTA and remain, overriding AHLTA's NKDA selection (unchecking the NKDA box).
 - If a patient has allergies listed in AHLTA, the NKDA checkbox is grayed out and cannot be selected until all allergies are deleted in AHLTA.

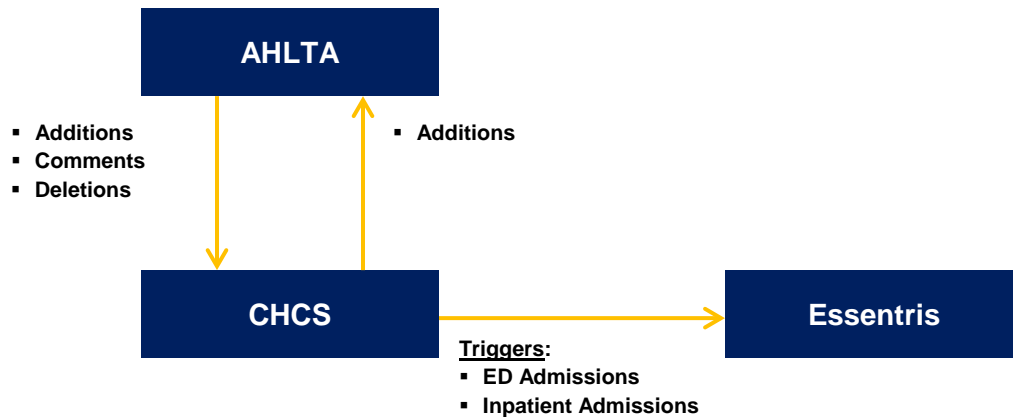


Figure 3.1.5-1: Communication of Allergy Information between Systems

3.1.6 Patient Weight



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When dispensing weight-based drugs, or prescriptions for patients 12 years of age and under, the patient's weight must be documented on at least one of the prescriptions. This process should be completed by the provider, but in the event that it is not, pharmacy staff shall follow the below procedures to document weight in the "PRESCRIPTION COMMENT" field of CHCS:

- Pharmacy staff shall confirm the patient's weight with the patient, or with the patient's parent and/or guardian, when they approach the window.
- Pharmacy staff shall enter the patient's weight in kilograms, using appropriate conversion equations from pounds when necessary.

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3.1.7 Perform Pregnancy/Lactation Query

Pharmacies shall display a sign at the pharmacy window to prompt patients to inform pharmacy staff if they are pregnant or lactating. This sign shall read:

“Some medications you take may be harmful to your baby if taken during pregnancy or while breast feeding. Please inform our pharmacy staff if you are pregnant or breast feeding.”

OR

“Attention: If You Are Pregnant or Breastfeeding, Please Inform Pharmacy Staff.”

CHCS upgrades are pending that will allow documentation of patient-specific information, such as pregnancy and lactation status. Once available, this information will be reviewed concurrently with clinical warnings.

If a patient does not provide information on their pregnancy or lactation status, the assumption will be that they are neither pregnant nor lactating.

Pharmacy staff will document positive pregnancy and lactation status in the “PRESCRIPTION COMMENT” field of CHCS utilizing the following guidance:

- To document pregnancy status, enter “PREG: Y”
- To document lactation status, enter “LACT: Y”

Pharmacy staff shall not document a pregnancy or lactation status unless the patient states that they are pregnant or lactating.

If the patient responds that she is pregnant and/or lactating, pharmacy staff will notify the pharmacist. The pharmacist will then verify the safety of the medication for the patient, and will ask the patient if they have any concerns about any other medications she may be taking.

Note: Pharmacy staff should remain cognizant of the sensitive nature of the pregnancy/lactation query and conduct this screening in an appropriate and respectful manner.

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3.2 Prescription Entering and Processing

All outpatient prescriptions are entered into CHCS. The outpatient pharmacy processes all prescriptions, reviews clinical warnings, and performs prescription edits. Prescription requests are processed and authorized for filling based on prescription type (e.g., AHLTA-Entered, Hard Copy, Transfer, Non-Formulary).

Independent Duty Corpsmen (IDC) may prescribe or provide medications carried on the IDC-specific MTF formulary, when approved in writing, by the local MTF Commanding Officer (CO).

The local Pharmacy and Therapeutics (P&T) Committee is responsible for developing and reviewing the IDC formulary. Controlled substances should not be included on the IDC-specific MTF formulary. For additional guidance on training, certifying, and supervising IDCs, refer to [Training, Certification, Supervision Program and Employment of IDCs \(OPNAVINST 6400.1\)](#).

Prescriptions submitted by telephone may only be accepted in emergency circumstances and must be dictated directly by the provider. Pharmacy staff must immediately transfer the prescription into writing and read it back to the provider for verification.

Prescriptions written by foreign-licensed providers will be accepted if the provider has been vetted by the Regional and/or Command credentialing authority.

3.2.1 Prescription Information Requirements

3.2.2 Process CHCS/AHLTA-Entered Prescription

3.2.3 Process Hard Copy Prescription

3.2.4 Process Prescription Transfer Request

3.2.5 Process Non-Formulary Prescription Request

3.2.6 Process Walk-Up Refill Request

3.2.7 Process Inpatient Discharge Prescription

3.2.8 Review Clinical Warnings

3.2.9 Correct Prescription Errors and Perform Edits

3.2.10 Outpatient Downtime Procedures

To return to the Table of Contents, click [here](#).

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3.2.1 Prescription Information Requirements

All prepared prescriptions must be in accordance with current applicable standards. In cases in which concern is expressed over the legitimacy of the prescription, the pharmacy staff will contact the provider to verify the valid nature of the prescription.



[MM01.01.01/1](#)

[MM05.01.09/3](#)

When reviewing all new pharmacy-prepared outpatient prescriptions, the following must be readily accessible:

- ✓ Two patient identifiers:
 1. Name AND
 2. Date of birth OR Department of Defense (DoD) identification number OR SSN
- ✓ Gender
- ✓ Diagnoses (when available)
- ✓ Current medications
- ✓ Patient allergies and sensitivities
- ✓ Patient weight in kilograms (for pediatric patients age 12 and under, and weight-specific medications)
- ✓ Patient height (when necessary)
- ✓ Pregnancy and lactation status (when necessary)
- ✓ Laboratory results (when necessary)



[MM04.01.01/2](#)

Current standards require all outpatient prescriptions to include the following information:

- ✓ Patient's full name
- ✓ Date prescription was written
- ✓ Patient's date of birth
- ✓ Generic or brand name of the medication
- ✓ Form of the medication
- ✓ Dosage size and strength written in the metric system
- ✓ Quantity of the medication to be dispensed

When entering the prescription into CHCS, ensure that the date entered is the date the prescription was written, vs. the date the prescription is filled.

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- ✓ Clear, concise directions to the patient
- ✓ Additional patient-specific data/parameters as required by regulation (when appropriate)
- ✓ Valid, identifiable name and signature of the prescriber
 - Electronic signatures are valid for prescriptions electronically-entered by MTF providers (i.e., through AHLTA)
 - Stamped signatures may be accepted (in accordance with state policy)
- ✓ Other requirements per Federal law

Pharmacy staff shall review all medications for clinical appropriateness based on medication, dose, and route of administration.

Controlled Substances

All prescriptions for Schedule-II-V medications must include, or have readily retrievable via CHCS, the electronic health record (EHR), or other automation processes, the patient's current address.

Controlled substance prescriptions written by a military provider must include the prescriber's branch of service or agency as well as his or her DOD identification number, SSN, or Drug Enforcement Administration (DEA) number.

Controlled substance prescriptions written by a civilian provider must include the prescriber's DEA number.

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3.2.2 Process CHCS/AHLTA-Entered Prescriptions

In some cases, there may be a delay in the transfer of AHLTA-entered prescriptions to CHCS. Patients whose prescriptions are delayed shall not be required to restart the queuing process. Instead, pharmacy staff will prioritize the patient in the queue once his or her prescriptions appear in CHCS, according to Pharmacy Department policy and staff discretion.

Once the prescriptions have appeared in CHCS, the following steps must be taken when processing AHLTA-entered prescriptions:

- ✓ Determine if any of the patient's prescriptions are for non-formulary medications. If yes, refer to [3.2.5 Process Non-Formulary Prescription Request](#) to determine the eligibility of the request.
- ✓ Determine if any of the patient's prescriptions are for refill medications. If yes, refer to [3.2.6 Process Walk-Up Refill Request](#) to determine the eligibility of the request.
- ✓ Verify prescription information for completeness and accuracy.
 - Refer to [3.2.1 Prescription Information Requirements](#).

When using the F11 key, be cognizant of all prescriptions assigned to that patient.

Review clinical warnings for each prescription being processed for the patient. See [3.2.8 Review Clinical Warnings](#) for further details.

If the prescription information is incomplete, inaccurate, or requires adjustment due to a clinical warning, pharmacy staff shall coordinate with the pharmacist and/or provider to edit the prescription in CHCS. Refer to [3.2.9 Correct Prescription Errors and Perform Edits](#) for further details.

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3.2.3 Process Hard Copy Prescription

The pharmacy will accept legal, hard copy prescriptions, including prescriptions written by a civilian provider outside of the MTF for formulary medications. Acceptance of these prescriptions should occur in accordance with the following parameters:

- Authorized prescribers employed by the MTF will submit prescriptions via electronic order entry, DD Form 1289, or NAVMED 6710/6. Refer to [Appendix E – Pharmacy Forms and Templates](#) to access a copy of these forms.
- Prescriptions submitted via fax are permitted when state policy allows.
 - Note: Schedule-II prescriptions are not valid if received via fax.

Prior to filling the prescription, pharmacy staff will determine if any of the patient's prescriptions are for non-formulary medications.

- If yes, refer to [3.2.5 Process Non-Formulary Prescription Request](#) to determine the eligibility of the request.
 - Refer to [7.1.5 Generic Medication](#) for information related to generic equivalents.
- If no, pharmacy staff shall follow the procedures outlined below.

If the patient presents with a hard copy prescription for a formulary medication, the subsequent steps must be followed:

- ✓ Verify that all required information is included on the prescription.
 - Refer to [3.2.1 Prescription Information Requirements](#) for further information.
- ✓ Perform prescription edits, if necessary. Any edits made to a hard copy prescription by a pharmacy technician must be verified by a pharmacist and initialed prior to CHCS entry. In locations where hard copy scripts are manually verified rather than scanned, a different-colored pen must be used by the pharmacist. For further details, refer to [3.2.9 Correct Prescription Errors and Perform Edits](#).
- ✓ Enter the appropriate prescription information into the corresponding fields in CHCS.
- ✓ Record the patient's date of birth on the hard copy prescription.
 - If the patient presents with multiple hard copy prescriptions at the same time, recording information on one of the prescriptions is sufficient to meet this requirement, assuming all prescriptions are filled at once.
- ✓ Review all clinical warnings. For further details, refer to [3.2.8 Review Clinical Warnings](#).

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If the prescription information is incomplete, inaccurate, or requires adjustment due to a clinical warning, pharmacy staff shall coordinate with the pharmacist and/or provider to edit the prescription in CHCS. Refer to [3.2.9 Correct Prescription Errors and Perform Edits](#) for further details.

Entering a New Provider into CHCS

When a provider's name is not found within CHCS, pharmacy staff shall follow the subsequent steps when entering a new provider into CHCS:

- ✓ Strike "Y" (yes) when CHCS prompts whether you are adding the provider as a new provider
- ✓ Strike "Y" (yes) when CHCS prompts whether the provider is an outside provider
- ✓ Follow CHCS prompts to include provider specialty (if known)
- ✓ Enter "Outside Provider" when prompted for the provider's class
- ✓ Enter "FCCA" (MEPRS code) under "Location"
- ✓ Enter the provider's unique ID
- ✓ Enter "No" under "Req. Provider ID"
- ✓ Enter provider's DEA number
- ✓ Enter "Civilian" as the provider's rank
- ✓ Enter provider's license number and National Provider Identifier (NPI) ID (if known)
 - Note: If the NPI ID is not located on the prescription, pharmacy staff can reference the [National Plan & Provider Enumeration System \(NPPES\)'s NPI Registry Search](#) function to locate this information

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3.2.4 Process Prescription Transfer Request

Prescriptions originally filled at an MTF may be refilled at another MTF if the prescription is for a medication stocked in that pharmacy and the patient presents with the original prescription label (including the prescription number).

Note: If a prescription transfer request cannot be completed immediately, the prescription shall be transcribed on a transfer form and the transfer shall be completed within 2 days of receiving the request. See [Appendix E – Pharmacy Forms and Templates](#) to access a copy of the prescription transfer form.

Prior to processing the prescription transfer request, pharmacy staff shall determine:

- ✓ If the patient has the original prescription bottle with the full prescription label intact:
 - If the patient does not have the original bottle with the full prescription label intact, pharmacy staff shall:
 - Refer to AHLTA for the pertinent information OR
 - Contact the original pharmacy to verify the refill with the pharmacist OR
 - Refer the patient to his or her provider for a new prescription.
- ✓ If the prescription was originally dispensed within the past year and includes at least one valid remaining refill:
 - If the prescription does not include at least one valid remaining refill, the transfer request shall not be processed and pharmacy staff shall refer the patient to his or her provider for a new prescription or to make an appointment.
 - The exception to this would be if the patient is requesting an emergent refill. If so, refer to [3.2.6 Process Walk-Up Refill Request](#).
 - If the prescription does include one valid remaining refill, pharmacy staff will review a patient's Pharmacy Data Transaction Service (PDTS) profile to verify the following information:
 - Days' supply
 - Drug name
 - Drug strength
 - Quantity

PDTS profiles will also indicate whether or not the prescription was filled at a retail pharmacy.

If the refill information cannot be verified through the patient's PDTS profile, pharmacy staff will contact the originating pharmacy to verify the validity of the

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refill. If the originating pharmacy cannot be reached, pharmacy staff will use clinical discretion when verifying the prescription.

If the prescription transfer request is valid, the following procedures must be followed to process the prescription transfer request:

- ✓ Verify that the following information is included on the prescription:
 - Refer to [3.2.1 Prescription Information Requirements](#).
- ✓ Enter prescription and provider information into the patient's CHCS profile as a new prescription.
- ✓ Review all clinical warnings. For further details, refer to [3.2.8 Review Clinical Warnings](#).
 - Note: Pharmacy staff at the receiving MTF should ensure that the prescription is not active at the transferring MTF.

For Schedule-III-V transfer requests, a pharmacist shall contact the original filling site in order to cancel the prescriptions and complete the transfer transaction.

The originating pharmacy will cancel all remaining refills for the prescription in CHCS to prevent duplicate prescriptions, and will include the following information in CHCS under "PRESCRIPTION COMMENTS":

- ✓ "Transferred to (pharmacy name)"
- ✓ Date of transfer

Prescription Transfers To/From Retail Pharmacies

Prescriptions originally filled at a retail pharmacy may also be refilled at an MTF, following the procedures included above in [3.2.4 Process Prescription Transfer Request](#).

Prescriptions that are being transferred should be reduced to writing, prior to being entered in CHCS. The MTF pharmacy will complete the transfer by contacting the original pharmacy to complete the transfer and documenting the following information in CHCS under "PRESCRIPTION COMMENTS":

- ✓ "Transferred to (name of retail pharmacy)"
- ✓ Contact information for pharmacy transferred from
- ✓ Pharmacist name at pharmacy transferred from
- ✓ Date of transfer
- ✓ Last fill date

When a Schedule-III-V medication is transferred from an MTF to a retail pharmacy, it may not be accepted for transfer back to an MTF.

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Note: Prescriptions shall be transferred to and from retail pharmacies in accordance with state law. However, it is recommended that a pharmacist complete all prescription transfers to and from retail pharmacies.

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3.2.5 Process Non-Formulary Prescription Request

Individual Commands may specify criteria, in addition to those listed below, when reviewing non-formulary requests. Navy Pharmacy Department Heads and/or Clinical Coordinators should actively engage with their respective P&T Committee to establish a non-formulary request process that includes the below criteria, as well as to review non-formulary medications that are frequently prescribed, for possible inclusion on the formulary.

If a patient presents with a prescription for a non-formulary medication, pharmacy staff shall make the following determinations, prior to filling the prescription:

- ✓ Determine if the prescription was authorized by an MTF provider. Pharmacies will generally not fill non-formulary items written by civilian providers. However, exceptions can be made on a case-by case basis, based on the pharmacist's professional judgment. For example, MTF pharmacies should fill prescriptions for patients that are referred to a non-MTF provider (i.e. specialty care) by the MTF.
- ✓ For the development of local criteria and templates for Medical Necessity and Prior Authorization Forms, refer to the [Department of Defense Pharmacoeconomic Center \(PEC\)](#).
- ✓ Determine if the patient has been previously prescribed the non-formulary medication or if the prescription continues existing therapy.
 - If the medication has not been previously approved or is not part of an existing therapy, a pharmacist must review the non-formulary request for approval.
- ✓ If the non-formulary prescription is approved for filling, refer to [3.2.2 Process CHCS/AHLTA-Entered Prescription](#).
 - Pharmacy staff shall record pharmacist review and approval. Pharmacy staff can record review and approval via in the patient's profile in CHCS using the following menu path:
 - ✓ Select "PDM"
 - ✓ Select "PPC"
 - ✓ Enter "NF approved [insert drug name] [insert date] [pharmacist initials or name]"

Note: Alternative methods to record pharmacist review and approval of non-formulary prescriptions can also be used.

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Options for Non-Formulary Prescriptions that are Not Approved for Filling

If the non-formulary prescription is not approved for filling, pharmacy staff shall explain to the patient the reason their prescription was denied and indicate the following alternate processes for filling the prescription:

1. Return the prescription to the provider for a prescription adjustment.
 - The pharmacist may contact the provider directly, on a case-by-case basis and in accordance with departmental policy, to discuss a prescription adjustment.
2. Utilize the [TRICARE Mail Order Pharmacy \(TMOP\)](#) option to fill the prescription.
3. Transfer the prescription to a civilian pharmacy for filling.

Pharmacy staff should educate patients presenting prescriptions for non-formulary medications about the Command formulary and inform them that they can access the formulary on the Command website.

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3.2.6 Process Walk-Up Refill Request

Process Walk-Up Refill Request

If a patient presents with a walk-up refill, pharmacy staff should fill the prescription and encourage the patient to call in the refill in the future, using the pharmacy's automated refill request system (e.g., AudioCare). Patients requesting walk-up refills will be prioritized at the end of the patient intake queue and receive lowest filling priority.

When counseling patients regarding the automated refill request system, pharmacy staff shall emphasize the following:

- Patients who use the automated refill system experience a reduced wait time as compared to patients who rely on walk-up refills.
 - If available, pharmacy staff should highlight the approximate wait time experienced by patients who use the automated refill system.
- Procedures for utilizing the automated refill request system.

For sites with an automated refill request system, use the CHCS "PHARMACY PATIENT COMMENT" field to identify patients who repeatedly do not adhere to the proper refill request process.

Process Emergency Walk-Up Refill Request

Pharmacies are permitted to fill emergency walk-up refills. Prescriptions for maintenance medications or a medication with an immediate medical necessity shall be considered emergent. Pharmacy staff may use their professional judgment to determine if the medication is needed immediately and should defer to the on-duty pharmacist if needed.

If a patient presents with an emergency refill request, pharmacy staff shall conduct the following procedures:

- ✓ Verify that the prescription was originally dispensed within the past year and includes at least one valid remaining refill.
 - If the patient's prescription fits these criteria, pharmacy staff may fill the prescription. For further information, refer to [3.2.2 Process CHCS/AHLTA-Entered Prescription](#).
 - If the patient has no valid refills remaining for the emergent refill, pharmacy staff must contact a pharmacist to review the request. If the patient is unable to obtain a new prescription, the pharmacist shall use professional judgment to dispense a one-time, limited fill of a maintenance medication. The amount should be reasonable to maintain the patient until the patient can contact their provider, but not exceed a 30-day supply.

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- The requested prescription may not be for controlled substances, with the exception of seizure control medications, which must be limited to no more than a 72-hour supply.

When Emergency Refills are approved, pharmacy staff should document them in CHCS by completing the following procedures:

- ✓ RNW the previous RX under authorizing provider name
- ✓ Strike “N” (no) when CHCS prompts whether to renew the prescription AS IS
- ✓ Adjust the quantity to the minimum required, with no refills
- ✓ Enter “Emergency Refill” under “PRESCRIPTION COMMENTS”
 - If the prescription is filled by the pharmacy technician, document the name of authorizing pharmacist under “PRESCRIPTION COMMENTS”

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3.2.7 Process Inpatient Discharge Prescription

Discharge medications are coordinated through the inpatient pharmacy and in accordance with departmental policy. Outpatient pharmacy staff shall work with inpatient pharmacy staff to ensure that discharge prescription orders entered into CHCS by the provider are processed. Refer to [2.5.7 Discharge Medications](#) for additional information on discharge medications.

3.2.8 Review Clinical Warnings

CHCS will conduct a drug warning check and verification against a patient's known allergies and current medication list. If a drug warning presents, the pharmacy staff may choose to override the warning.

Clinical warnings must be reviewed for all outpatient medication orders. Review of clinical warnings must include a drug warning review and a review of allergy, duplicate medication, and drug class warnings.

Pharmacy staff shall review all clinical warnings before filling a prescription and record their revision in the CHCS "OVERRIDE COMMENTS" field, according to the following procedures:

- *Drug Warning Review:* Pharmacy staff shall enter a comment for all cleared warnings. Pharmacy technicians may only clear moderate drug interaction warnings; all severe (level 1) warnings must be reviewed by a pharmacist with a specific reason entered into the CHCS "OVERRIDE COMMENTS" field.

If an override is not acceptable, there is concern about the order, or a pharmacist or Licensed Independent Practitioner (LIP) cannot be reached, pharmacy staff will contact the prescriber. Within CHCS, pharmacy staff will choose to deny the override and select the appropriate reason for denying the override.

All interaction and moderate warning messages shall be retrospectively reviewed by a pharmacist via override reports when prospective review is not available. This shall be completed when a pharmacist is next on duty and shall include documentation of any follow-up action.

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3.2.9 Correct Prescription Errors and Perform Edits

If pharmacy staff identifies the need to correct a prescription error or make a prescription edit, the following steps shall be taken:

- *Pharmacy-Caught Clinical Error:* A pharmacist or pharmacy technician, in consultation with the final reviewer, may make edits to an AHLTA-entered or hard copy prescription including, but not limited to, drug name and drug strength. The final reviewer should be informed of any clinical edits made, and a pharmacist must be made aware of changes to drug name, strength and directions that change the daily dosage.

A pharmacist or pharmacy technician must contact the prescriber to confirm before making any edits that change the clinical intent of the prescription.

- *Pharmacy-Caught Non-Clinical Error:* When an edit that does not impact the clinical intent of the order is required, a pharmacist shall determine the required change and use his or her professional judgment to determine if provider contact is necessary to confirm the prescription edit. A pharmacy technician may contact the provider regarding the edit, but a pharmacist must review the edit before dispensing to the patient.

A pharmacy technician may make edits to the following prescription details (and corresponding CHCS fields) without consulting a pharmacist:

- *Days Supply:* Pharmacy staff, including pharmacy technicians, are authorized and expected to update days supply based on the quantity prescribed and the dosage entered by the prescriber in AHLTA.
- *SIG Clarification:* Pharmacy staff, including pharmacy technicians, is authorized to make edits to a prescription's SIG (e.g., dosage form change, correct SIG wording so that directions come across clearly).
- *Order Date, Quantity, Refills:* Pharmacy staff, including pharmacy technicians, are authorized to edit the prescription date, medication quantity (based on available pharmacy stock), and number of refills remaining in order to reflect accurate information.

All changes to prescriptions will be documented in CHCS. For hard copy prescriptions, the pharmacy staff shall also document any changes on the CHCS label and on the front of the prescription in different colored pen and note his or her initials (or other unique identifier). For prescriptions entered in CHCS or AHLTA, the pharmacy staff shall note any changes on the printed CHCS label/monograph in order to alert the pharmacist of the prescription change.

If a pharmacist is unavailable, a LIP must review all changes, or the pharmacy technician may contact the provider to resubmit the prescription. Pharmacy staff shall contact the provider if any questions remain about the prescription in order to discuss necessary edits.

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3.2.10 Outpatient Downtime Procedures

During facility downtime Commands are expected to provide an appropriate level of care, as determined by Command capacity, patient population, and the pharmacist's clinical and professional judgment.

Downtime situations may be the result of either scheduled or unscheduled downtime:

- *Scheduled Downtime:* Scheduled downtime is defined as downtime of one or more hospital information systems planned in advance for either routine maintenance or for an upgrade. Scheduled downtime normally occurs overnight, or at the end of the month, to minimize the interruptions to patient care and pharmacy workflow.
- *Unscheduled Downtime:* Unscheduled downtime is defined as unexpected downtime of one or more hospital information systems, due to equipment failure and/or network issues. Unscheduled downtime prevents operation of the standard pharmacy workflow and can impact patient care. Unscheduled downtime must be communicated to the appropriate personnel immediately.

In the event that downtime occurs, the following procedures must be followed:

- [CHCS Downtime Procedures](#)

For additional information on downtime procedures, refer to [7.5 Continuity of Operations Plan \(COOP\)](#).

CHCS Downtime Procedures

In preparation for scheduled CHCS downtime, batch labels must be double printed. All prescriptions not added to the computer during downtime should be saved in a separate area and should have the number of doses dispensed indicated on the prescription. Additionally, pharmacy staff should keep ad hoc prescription labels on hand to be used during scheduled and unscheduled CHCS downtime.

In the event that CHCS is inoperable, the CHCS outage must be communicated to the appropriate individuals. If the downtime occurs during normal working hours, contact the Pharmacy Department Head, as well as the Pharmacy System Manager or Medical Information Department (MID) about the CHCS outage.

Note: If unscheduled CHCS downtime occurs after normal working hours, contact the MID or the Officer of the Day AND the pharmacist on duty.

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If CHCS downtime is expected by the MID to occur for a period longer than 15 minutes, and back-up technology (such as RxOrder) is not available, the following steps shall be taken:

- ✓ Communicate to patients in the waiting room the expected length of the system outage (if known) and indicate that modified operations will affect their prescription wait time.
 - Pharmacy staff shall use the following language when communicating downtime to patients: “We are experiencing a system downtime, and we have communicated with the Medical Information Department who has informed us that the downtime is expected to last for X minutes. Due to modified operations, we will be triaging patients. This will affect your wait time, and we encourage patients to return at a later date to collect their prescriptions, if you are able to do so.”
- ✓ Inform patients in the waiting room with AHLTA-entered prescriptions that they must return to their provider to obtain a hard copy prescription, if they wish to receive their medication during the downtime.
 - Refer to [3.2.3 Process Hard Copy Prescription](#) for further information on how to accept and process hard copy prescriptions.

In addition, the following steps shall be taken for order entry and processing:

- ✓ Prepare all prescription labels.
 - If the network is inoperable, but the pharmacy has power, pharmacy staff shall use a back-up label printer (if applicable) to generate prescription labels. During a full power and network outage, pharmacy staff will manually prepare all prescription labels.
 - Refer to [3.3.4 Prepare Prescription Labels](#) for necessary information to include on labels.
- ✓ Prescriptions will be triaged for prioritization according to medical need and site capability.
- ✓ For prescriptions with refills remaining, inform the patient that they must contact the pharmacy for the CHCS generated prescription number prior to ordering their next refill as downtime prescription numbers will not correlate with the original prescription number once the downtime prescriptions are entered in CHCS.
- ✓ Record the outage in the Pharmacy Departmental Log or a separate CHCS Downtime Log. The log entry must include the following information:
 - Time of the CHCS outage.
 - Details related to CHCS outage.

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- Last non-controlled, Schedule-II, and Schedule-III-V prescription numbers generated by CHCS.
 - If using RxOrder during downtime, it is not necessary to document this information.

Once the system returns to operation, orders must be entered into CHCS as soon as possible and checked by a pharmacist.

When CHCS is brought back online, the following information must be added to the log entry:

- ✓ Time that CHCS came back online.
- ✓ Last non-controlled, Schedule-II, and Schedule-III-V prescription numbers manually entered into CHCS.

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3.3 Prescription Filling

Following prescription entry and processing, pharmacy staff selects a CHCS label from the designated basket or bin of processed prescriptions, and follows the appropriate steps below depending on whether the medication is filled through automation, manually filled, or is a controlled substance.

If a patient has multiple prescriptions to be filled, all prescriptions the pharmacy is able to dispense must be filled before final verification is performed. Prescriptions that have been filled and await final verification shall be placed in patient-specific containers (i.e., bins or bags).

Note: In cases in which a patient is picking up prescriptions for more than one member of the same family, pharmacy staff may place the prescriptions in patient-specific bags within a larger family bag. Consider writing the names of each family member on the outside of the bag to make clear which patients' prescriptions are within the bag.

3.3.1 Prepare Automation-Filled Prescription

3.3.2 Prepare Manually-Filled Prescription

3.3.3 Prepare Controlled Substance Prescription

3.3.4 Prepare Prescription Labels

3.3.5 Verify Prescription Quantities

3.3.6 Document and File Prescriptions Filled

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3.3.1 Prepare Automation-Filled Prescription

Depending on the type of automation used at the pharmacy, pharmacy staff may need to scan the CHCS label at the automation terminal to queue the prescription for filling. In other instances, CHCS will automatically queue the automation upon processing the prescription.

The automation will fill the prescription for pharmacy staff retrieval. Depending on the type of automation used, pharmacy staff may need to seal the prescription bottle and affix the prescription label to the bottle.

For information that must be included on prescription labels, refer to [3.3.4 Prepare Prescription Labels](#).

3.3.2 Prepare Manually-Filled Prescription

When possible, prescriptions should be filled through the automation system; however “slow-movers,” compounded and prepackaged medications are often manually-filled. When manually filling a prescription, the pharmacy staff shall remove the appropriate medication from the pharmacy stock, use barcode scanning (if available) to check the medication and, unless dispensing the full bottle or package, count out the prescribed dose and place in a new prescription bottle. Pharmacy staff will then affix the prescription label to the bottle or package.

- Pharmacists will consult the compounding guidelines and pre-packing instructions for all compounded and prepackaged pharmaceuticals provided in the Draft DoD Compounding Pharmaceuticals Recipe Book, which can be accessed on the [Navy Pharmacy NKO Page](#).
- Pharmacy staff will also adhere to the intent of applicable [United States Pharmacopeia \(USP\) 795](#) and [797](#) guidelines related to non-sterile and sterile compounding. For further information on compounding operations, refer to [8.0 Compounding Operations](#).

All compounded and pre-packed prescriptions must be recorded in separate logbooks. When assigning lot numbers to compounded medications, the lot numbers must also be recorded in a Compounded Lot Assignment Book. See [Appendix E – Pharmacy Forms and Templates](#) for further information on the Compounded Lot Assignment Book.

Refer to [7.1.11 Lot Number Generation](#) for instructions on generating lot numbers. For information that must be included on prescription labels, refer to [3.3.4 Prepare Prescription Labels](#).

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3.3.3 Prepare Controlled Substance Prescription

MTFs shall use the standardized dispense, inventory, and requisition forms to audit and monitor Schedule-II-V drugs and drugs with a high potential for diversion (DHPDs) from receipt into inventory until dispensing and should follow the instructions for electronic inventory provided in the vault functions of the appropriate technology (i.e., Pyxis or CHCS).

Controlled substance prescriptions must be filled within a specific period of time:

- *Schedule-II Prescriptions:* Prescriptions for Schedule-II medications must be filled within 30 days of the date originally written. Exceptions to this restriction may be made in accordance with State and Federal law.
- *Schedule-III-V Prescriptions:* Prescriptions for Schedule-III-V medications must be filled within six months of the date originally written. If authorized by the provider, these prescriptions may be refilled up to five times within six-months of the date written.

If the pharmacy receives a controlled substance prescription for a medication that is not in their working stock, and the main narcotics vault is not operated within the pharmacy, they will call, fax, or deliver the order to the main narcotics vault for filling.

All Schedule-II prescriptions must be counted out and back-counted against the recorded stock bottle level, and verified against the appropriate perpetual inventory record. If a discrepancy arises that cannot be resolved within the pharmacy, the Pharmacy Department Head shall coordinate an investigation with the Controlled Substances Inventory Board (CSIB).

A NAVMED 6710/1 form or equivalent electronic documentation must be completed for all Schedule-II prescriptions. See [Appendix E – Pharmacy Forms and Templates](#) to access a copy of NAVMED 6710/1.

For information that must be included on prescription labels, refer to [3.3.4 Prepare Prescription Labels](#). For additional information on inventorying controlled substances, refer to [9.0 Controlled Substance Operations](#).

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3.3.4 Prepare Prescription Labels



[MM03.01.01/7](#)

[MM05.01.09/2](#)

All prepared prescriptions must be labeled in accordance with current applicable standards. Current standards require all outpatient prescription labels to include the following information:

- ✓ The MTF dispensing the prescription, including the pharmacy telephone number
- ✓ Identifying prescription number
- ✓ Patient name
- ✓ Date filled (whether original or refilled)
- ✓ Clear, concise directions to the patient
- ✓ Full name of drug, strength, and quantity dispensed
 - Pharmaceutical preparations will normally be identified and labeled with the generic name. However, trade or brand names may be used if the trade or brand name product is actually in the container. The use of “type” or “eq.” is acceptable on the label (e.g., Tenormin “type”).
- ✓ Prescriber name
- ✓ Prescription filler’s initials or numeric identifier (when not supported through automation)
- ✓ Number of refills remaining
- ✓ Beyond-use date, if applicable
- ✓ Proper auxiliary or cautionary labels as indicated
- ✓ Other requirements per Federal law

When possible, pharmacy staff should avoid labeling prescriptions with “use as directed,” “as needed,” or “PRN.” If a prescription is labeled as such, pharmacy staff shall communicate the means of use to the patient prior to dispensing the prescription.

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3.3.5 Verify Prescription Quantities

Acceptable quantities of medication to be dispensed in a prescription vary depending on whether or not the prescription is for a controlled substance, and whether or not the patient is deploying.

- [Non-Controlled Medication](#)
- [Controlled Substances](#)
- [Deployment Situations](#)

Non-Controlled Medication

In most circumstances, prescriptions for non-controlled medication can contain no more than a 100-day supply of the medication. The following are exceptions to this limit:

- Patients using contraceptives on a long-term basis may be dispensed up to six months of medication at a time with one refill, when indicated on the prescription.
- Additional exceptions may be made based on medical necessity (including during deployment situations).

Controlled Substances

In most circumstances, Schedule-II prescriptions can contain no more than a 30-day supply and Schedule-III-V prescriptions can contain no more than a 100-day supply. Two exceptions to this limit are:

- Stimulant medications, which include medication to treat Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD), may be provided at up to a 100-day supply.
- Controlled substances for deploying personnel with orders:
 - *Schedule-II Medications*: Generally up to a 90-day supply.
 - *Schedule-III-V Medications*: Generally up to a 180-day supply.
 - Additional exceptions may be made based on medical necessity in order to meet deployment readiness.

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Deployment Situations

Active duty personnel preparing for deployment, and other deploying beneficiaries with orders, shall receive medications in accordance with the below procedures. In a deployment situation, the ideals and standards of pharmacy practice should remain consistent. This Navy Pharmacy SOP, along with the [Manual of the Medical Department \(MANMED\) Chapter 21: Pharmacy Operation and Drug Control](#), should be used as references to establish the standards of a deployed pharmacy practice in conjunction with area of responsibility (AOR) policies. Refer to the [Military Vaccine Agency](#) for additional information related to vaccines specific to individual AORs.

All efforts shall be made to educate patients on the availability of [TRICARE Mail Order Pharmacy \(TMOP\)](#) for their prescription delivery needs during deployment.

While general guidelines for the acceptable quantities of a medication that may be dispensed to Navy Pharmacy patients are listed above, exceptions may be made in deployment situations. These exceptions may be made based on medical necessity to meet deployment readiness requirements. In such circumstances, medication expiration dates and AOR-specific policies must still apply.

- *Non-Controlled Medication:* Deploying personnel may be dispensed non-controlled medication in quantities sufficient to meet deployment readiness requirements and based on medical necessity.
- *Schedule-II Medication:* In general, deploying personnel may receive up to a 90-day supply of Schedule-II medications, with the exception of stimulant medications, which may be dispensed in a 100-day supply. Additional exceptions may be made based on medical necessity in order to meet deployment readiness requirements and in coordination with the patient's provider or unit senior medical officer.
- *Schedule-III-V Medication:* In general, deploying personnel may receive up to a 180-day supply of Schedule-III-V medications. Additional exceptions may be made based on medical necessity in order to meet deployment readiness requirements and in coordination with the patient's provider or unit senior medical officer.

Note: when deployment scenarios arise that may require controlled substances in excess of what would normally be dispensed, code 21 U.S.C permits the dispensing of these medications. Refer to the [DEA Office of Diversion Control](#) for additional information.

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3.3.6 Document and File Prescriptions Filled



[MM05.01.11/2](#)

Copies of all hard-copy prescriptions filled by the pharmacy shall be maintained on file for a period of two years. Prescriptions for non-controlled substances, Schedule-II medications and Schedule-III-V medications shall be placed in separate files.

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3.4 Prescription Final Verification

Depending on prescription type, some medications require that a pharmacist or pharmacy technician verify the prescription information and contents before dispensing.

3.4.1 [Verify Prescription Information](#)

3.4.2 [Additional Prescription Verification Processes](#)

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Outpatient Pharmacy Operations

3.4.1 Verify Prescription Information

When performing final prescription verification, pharmacy staff must follow the subsequent procedures:

- ✓ Check medication for accuracy.
 - For barcoded prescriptions, scan the prescription at the automation station and verify medication against the picture that appears.
 - For manually-filled prescriptions or liquids that have been poured into an alternate container, verify medication against the stock bottle.
- ✓ Verify the information on the outpatient prescription label.
 - Refer to [3.3.4 Prepare Prescription Labels](#) for details.
- ✓ Review comments entered in the “PRESCRIPTION COMMENTS” field in CHCS.
- ✓ Determine if any revision to the prescription is necessary.
 - If revisions are necessary, refer to [3.2.9 Correct Prescription Errors and Perform Edits](#) for further details.

If no pharmacist is available, an active-duty or military-trained pharmacy technician may review and dispense ONLY the following prescriptions without prospective pharmacist review:

- New AHLTA-entered formulary medication prescriptions not on the “Must Contact Pharmacist” List at active-duty only clinics.
- Prescription refills for all beneficiaries.

All other prescriptions must be reviewed by a pharmacist prior to dispensing. The pharmacist must verify the prescription information and notation on all filled medications against the prescription information listed on the CHCS label. If a pharmacist is unavailable to review the prescription and the prescription requires a pharmacist review, pharmacy staff must either:

- Follow Telepharmacy procedures (refer to [3.4 Prescription Final Verification](#)) for remote pharmacist review of the prescription OR
- Wait for the pharmacist to return OR
- Contact a LIP to review the prescription and verify the necessary information as provided in [3.4 Prescription Final Verification](#).

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3.4.2 Additional Prescription Verification Processes

In addition to the verification processes listed in [3.4.1 Verify Prescription Information](#), the following prescriptions require further verification prior to being dispensed:

- [Hard Copy Prescription](#)
- [Schedule-II Medication Prescription](#)
- [Weight and/or Age Specific Prescription](#)

Hard Copy Prescription

When verifying hard copy prescriptions, pharmacy staff must confirm that the following information is included on at least one of the patient's prescription:

- ✓ Patient's date of birth
- ✓ Relevant drug allergies
- ✓ Filling pharmacy staff member's signature or initials, unless previously captured by automation
- ✓ Changes made to the prescription are clearly visible

Civilian hard copy prescriptions for controlled substances must also include the prescriber's DEA number.

Schedule-II Medication Prescription

Prior to dispensing a controlled substance prescription, the subsequent additional steps must be followed:

- ✓ When verifying a Schedule-II prescription, a pharmacist or pharmacy technician must perform a secondary count of the dispensing medication amount in the bottle against the quantity indicated on the prescription label.
 - If the count is inaccurate, the pharmacy staff will make appropriate corrections to the dispensing amount.
 - Consider affixing a tamper-evident seal to Schedule-II medication bottles and having the prescription verifier initial the seal.

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Weight and/or Age Specific Prescription



Prior to dispensing a weight and/or age-specific prescription, the following steps must be taken to verify the prescription:

- ✓ Pharmacist must verify patient weight and/or age.
- ✓ Pharmacist must verify the appropriateness of the medication type and dose against patient weight and/or age.

If pharmacy staff determines that prescription edits are required, they may need to contact the provider to review and discuss the edits.

Refer to [3.2.9 Correct Prescription Errors and Perform Edits](#) for further details.

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3.5 Prescription Dispensing

Once filled, prescriptions are dispensed to the patient following patient counseling or held temporarily for patient pick-up. If the patient fails to pick-up their medication it is returned to stock.

A prescription may only be dispensed once it has received its final check.

3.5.1 Verify Patient Identification

3.5.2 Patient Medication Verification

3.5.3 Perform Patient Counseling

3.5.4 Dispense Prescriptions

3.5.5 Dispense Over-the Counter (OTC) Medication

3.5.6 Dispense Brig Patient Prescriptions

3.5.7 Return to Stock

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3.5.1 Verify Patient Identification

If the patient does not leave the window and a second verification is not required, go to [3.5.2 Patient Medication Verification](#).

Once the prescription is filled and ready for dispensing, the patient shall be called to the window. All patients shall be called to the window either through the appropriate queuing system or verbally. Patients must be provided sufficient time to arrive at the window for pick-up.

Patient Self Pick-Up

In accordance with Joint Commission National Patient Safety Goals, each patient shall provide the following two identifiers when picking up a personal prescription:

1. **First Patient Identifier:** Patient's name, as displayed on a valid, government-issued picture ID. Accepted forms of identification include a valid U.S. Uniformed Services ID card OR valid CAC.

Note: Pharmacy personnel are empowered to use professional judgment to make exceptions for a patient who forgets to bring his or her valid, government-issued picture ID. If the patient is able to provide other identifying information, pharmacy personnel can use good judgment to authorize an exception. Pharmacy personnel can use this opportunity to educate about the patient about bringing his or her valid, government-issued picture ID to future visits.

2. **Second Patient Identifier:** Patient's date of birth, as recorded in his or her CHCS profile (preferred) OR SSN OR U.S. Department of Defense (DoD) identification number.

Note: As part of the patient identification process, pharmacy staff must confirm that the patient is of an appropriate age to pick-up a personal prescription, in accordance with state law. For Outside the Contiguous United States (OCONUS) Military Treatment Facilities (MTFs), refer to the [Informed Consent for Medical and Dental Treatment Instruction \(BUMEDINST 6320.16\)](#).

If applicable, refer to [3.1.2 Patient Identification](#) to reference your Command's policy on appropriate age to pick up a personal prescription.

Foreign nationals who fall within the Command's scope of services, and who present to pick up a personal prescription without appropriate identification, should be directed to the facility's patient administration office to obtain a valid form of ID prior to returning to the pharmacy.

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Patient Pick-Up for Other Beneficiary

In accordance with HIPAA regulations, agents of the patient (e.g., relatives, friends) may pick up prescriptions on the patient's behalf when the patient's agent can demonstrate BOTH:

1. Accurate identification of the patient using a minimum of 2 identifiers. The person presenting to collect the medication must prove the identity of the patient by providing one of the following in addition to the second identifier as noted above:
 - Patient's valid U.S. Uniformed Services ID or CAC OR
 - Front and back copy of valid U.S. Uniformed Services ID or CAC OR
 - Power of attorney
2. Accurate identification of the following:
 - Specific medication(s) OR
 - Type(s) of medication (e.g., pain medication, antibiotic, cold meds, birth control pills)

Note: Pharmacy personnel are empowered to use professional judgment to make exceptions for a patient who forgets to bring or does not have a photocopy or electronic copy of the other beneficiary's valid government-issued identification card. If the patient is able to provide other identifying information, pharmacy personnel can use good judgment to authorize an exception.

Pharmacies may implement additional measures to facilitate pick-up by a patient's agent (i.e., a locally developed form, signed by the patient to authorize another person to pick up prescriptions). However, additional measures should not result in barriers to care when the patient's agent can satisfy both above HIPAA related requirements.

Foreign nationals who fall within the Command's scope of services, and who present to pick up a prescription for another beneficiary without appropriate identification, should be directed to the Patient Administration Office to obtain a valid form of ID prior to returning to the pharmacy.

If a patient fails to present at the window, refer to [3.5.7 Return to Stock](#).

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3.5.2 Patient Medication Verification

Once the patient's identification has been verified, all medication labeling must be verified against the patient's information.

- *DRX CHCS Profile Check (if required)*: Once the patient's identification has been verified the pharmacy staff member must verify with the patient the quantity, type and dosage of medications that have been filled. If any items have not been filled due to not in stock (NIS) or other circumstances, the patient should be consulted on next steps.
- *Prescription Bag Verification*: Each prescription bag shall be verified to ensure correct bag contents and patient information label. At a minimum, the patient bag must be labeled with the patient's name and indicate storage instruction (e.g., refrigeration required).

If the prescription filled is incorrect, pharmacy staff shall correct the prescription immediately. If the prescription cannot be filled in a timely manner, the patient must be prioritized within the pharmacy workflow.

Show and Tell

As part of dispensing, pharmacy staff must complete the following steps during the Show and Tell process:

- Pull each prescription from the prescription bag and verify the patient's identification against the prescription label
 - Consideration should be given to opening the bottle and displaying the patient's medication.
- Show patient their prescription(s) and, at minimum, counsel the patient on the following:
 - Name of medication.
 - Administration directions for each medication.

Before dispensing the prescription, pharmacy staff must ask the patient if all of the information they received is understood and if the patient has any questions. A patient should be offered a confidential area for discussion of medication and medication treatment if warranted or requested.

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3.5.3 Perform Patient Counseling

Every patient shall be offered patient counseling from the pharmacy staff upon receiving their prescriptions. In conjunction with Omnibus Budget Reconciliation Act of 1990 (OBRA 90), patients shall also be offered the opportunity to speak to a pharmacist.

All patient counseling should be in compliance with [NAVMED POLICY 10-005, Navy Pharmacy Assessment of Barriers to Learning Policy](#), which establishes the minimum requirements pharmacy staff should use when determining barriers for learning.

Refer to HIPAA regulations and the [TRICARE Management Activity \(TMA\) Privacy and Civil Liberties Office](#) for information on protecting and supporting information privacy.

Medication Guides

In accordance with the U.S. Food and Drug Administration (FDA) and according to Bureau of Medicine and Surgery (BUMED) Memo of 20 July 2012, "Provider and Pharmacist Training on Mefloquine Usage for Malaria Prophylaxis," the FDA medication guide and wallet card will be dispensed for all mefloquine prescriptions. Refer to the [Navy Pharmacy NKO Page](#) to access this training.

- If appropriate, given pharmacy technology, patients will sign the electronic signature pad to indicate receipt of the FDA medication guide.

Patient Education Monographs

A patient education monograph (PEM), as printed from CHCS using the First Data Bank drug information, will be provided to the patient with each new prescription dispensed.

Additional Drug Interaction Counseling

If a patient inquires about medication interactions not previously addressed through the clinical warnings screening process (see [3.2.8 Review Clinical Warnings](#)), pharmacy staff may utilize CHCS or other existing software to screen for interactions. When using CHCS to screen for interactions in these situations, pharmacy staff should use the "TEST DRUGS FOR WARNINGS" (TFW) function and manually enter the medications in question.

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3.5.4 Dispense Prescriptions

DRX indicates that the prescription has been dispensed to the patient. Pharmacies shall only DRX in CHCS after a medication is dispensed, not at check-in.

When dispensing a Schedule-II medication, the patient or patient's agent must sign the back of the prescription or CHCS label to confirm they have receipted the prescription (when applicable, patients must sign the electronic signature pad organic to the technology). This record is then filed in pharmacy for a two-year period. Pharmacies may elect to require signatures for Schedule-III-V prescriptions as well.

3.5.5 Dispense Over-the Counter (OTC) Medication

Although over-the-counter (OTC) programs are discouraged at locations not supporting recruit training, Commands electing to offer OTCs without a prescription (commonly known as the OTC Handout Program) are required to follow [MANMED Chapter 21](#) Article 21-5.

In accordance with [Comprehensive Tobacco Control for Navy Medicine \(BUMEDINST 6200.12A\)](#), pharmacy staff participates in the development of local MTFs' Tobacco Cessation (TC) prescribing policy and ensures that TC pharmacotherapy is available in the pharmacy.

Note: At a minimum, the following forms of TC pharmacotherapy should be available: nicotine replacement therapy in the form of gum and patch, bupropion sustained release (SR), and varenicline pursuant to local MTF protocol.

Local policy may not place limitations on which providers may prescribe formulary TC pharmacotherapy and cannot require enrollment in a TC program in order to receive TC pharmacotherapy.

In accordance with BUMED Memo of 26 March 2010, "[NAVMED 10-006 Prescribing, Dispensing, and Distributing of \(Levonorgestrel 0.75MG\) Next Choice® or Plan B, Generic Tablets](#)," Next Choice® or Plan B, Generic Tablets are emergency contraceptive drugs approved by the FDA for the prevention of pregnancy after a contraceptive failure or unprotected sex.

Next Choice® and Plan B, generic tablets are designated as Basic Core Formulary and therefore must be on the MTF formulary. Next Choice® and Plan B, generic tablets have been approved by the FDA as both prescription and OTC products with specific age restrictions; individuals younger than 17 will require a prescription while those 17 years of age and older do not require a prescription.

- Responsibilities:
 - MTF commanders, commanding officers, and officers-in-charge will ensure that each MTF pharmacy develops and implements procedures for ordering, storage, dispensing, distributing, and accounting of Next Choice® and Plan B, generic tablets, per this policy.

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- Every patient receiving Next Choice® and Plan B, generic tablets will be given a patient handout provided by the manufacturer.
- Each MTF commander, commanding officer, and officer-in-charge will develop policies to ensure that patients are able to receive Next Choice® and Plan B, generic tablets when their healthcare provider or pharmacist has moral or ethical beliefs that conflict with the prescribing, dispensing, or distributing of Next Choice® and Plan B, generic tablets.
- Policies and Procedures:
 - Documentation
 - The responsible healthcare provider will ensure that all distributions of Next Choice® and Plan B, generic tablets, whether by prescription or OTC, are entered into the patient's electronic medical record and the AHLTA medication profile. If AHLTA is not available, documentation will be made in the patient's paper medical record.
 - MTF Pharmacies
 - MTF Pharmacies shall make available and dispense Next Choice® or Plan B, generic tablets as an OTC to beneficiaries 17 years of age and older and record it in CHCS as an OTC prescription.
 - Beneficiaries under 17 will require a non-refillable prescription for each dispensation.
 - Males requesting Next Choice® or Plan B, generic tablets must present their military identification card and the identification card of the eligible female beneficiary who will consume the medication.
 - Procedures for the stock and replenishment of Next Choice® or Plan B, generic tablets will be established, coordinated, and monitored by the local MTF pharmacy.
 - MTF Emergency Room (ER)
 - ER distribution of Next Choice® or Plan B, generic tablets must be by a licensed healthcare provider and per local MTF policy.
 - ER distribution must be directly to the patient taking the medication.
 - Local policy governing ER distribution of Next Choice® or Plan B, generic tablets must be consistent with local policy governing ER procedures for distributing medication after the main pharmacy is closed.
- Limitations:

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- Dispensation of Next Choice® or Plan B, generic tablets will not exceed 2 packs in 6 months per patient.
- Additional dispensing of Next Choice® or Plan B, generic tablets to a patient in excess of 2 packs in 6 months will be by prescription. Patients will be counseled on this requirement by the person dispensing the initial pack.

3.5.6 Dispense Brig Patient Prescriptions

A brig staff member will collect filled prescriptions for brig patients from the pharmacy to transport to the brig. The brig staff member maintains custodial responsibility for the medication until dispensed to the appropriate patient.

Note: At minimum, a brig staff member must sign the back of every Schedule-II prescription collected, or capture signature via an electronic signature pad, to confirm receipt.

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3.5.7 Return to Stock

When a patient fails to pick up their filled prescription, the prescription shall be placed on a dispensing shelf for a maximum of **14 calendar days**.

Note: In the case of controlled substances, Schedule-II-V prescriptions shall be secured with the controlled substance working stock.

Pharmacy staff shall regularly monitor dispensing shelves to review prescriptions that have not yet been picked up by patients. The prescription may be returned to stock once pharmacy staff has reviewed the medication for suitability for reuse. Patients will not be penalized a refill due to failure to pick up their prescription.

Pharmacy staff may utilize the CHCS "NON-COMPLIANCE REPORT" (NCR) to identify prescriptions that have not yet been picked up by patients and need to be returned to stock.

Prescriptions returned to stock will be marked noncompliant in CHCS. A noncompliant prescription status remains **ACTIVE**; however, an asterisk (*) precedes the prescription on the patient's prescription profile. When pharmacy staff logs a prescription as noncompliant, the system updates the remaining refills accordingly, except for partial prescriptions.

The following steps shall be followed to manually log a prescription as noncompliant:

- ✓ Type **^NON** (or OPM-PM-SPM-NON)
- ✓ Select the appropriate prescription(s)
- ✓ CHCS will display the following message, "REFILLS REMAINING HAS BEEN UPDATED AND THE RX HAS BEEN LOGGED NONCOMPLIANT"

The following steps shall be followed to automatically set up appropriate site parameters to perform this function automatically:

- ✓ Type **^SIT** (or SFM-OMM-SIT)
- ✓ Select the correct pharmacy site
- ✓ Set the field **PICKUP GRACE PERIOD** to 14 days
- ✓ After 14 days, the prescription is automatically logged as noncompliant in CHCS

At the point the medication is returned to stock, the expiration date will be one year from the fill date, or the manufacturer's expiration date, whichever is soonest.

Note: When medication is returned to stock, pharmacy staff must ensure physical destruction of the patient's name and corresponding label material on the prescription vial to prevent any future identification of the patient from the prescription label. Alteration must be done in a way such that identification of the original fill dates and product information is maintained. Use of a permanent marker alone over a patient's name is NOT acceptable. .

Navy Pharmacy SOP: Telepharmacy Operations

4.0 TELEPHARMACY OPERATIONS

The procedures stated within this Section of the Navy Pharmacy Standard Operating Procedure (SOP) apply to Telepharmacy operations. All Telepharmacy procedures included within this Section assume the use of ScriptPro Telepharmacy technology.

Using ScriptPro Telepharmacy technology, sites without a pharmacist (“**Remote Site**”) can contact a site with a pharmacist (“**Support Site**”) in order to complete pharmacist verification and consultation procedures related to outpatient prescription processing and dispensing.

In addition to the support materials and information provided by ScriptPro directly to individual Commands, the [ScriptPro website](#) provides additional information, including instructional guides and videos.

Telepharmacy operations align with outpatient pharmacy operations. The following Critical Duties are to be executed following the completion of [3.1 Patient Check-In](#), [3.2 Prescription Entering and Processing](#), and [3.3 Prescription Filling](#):

4.1 [Prescription Final Verification](#)

4.2 [Prescription Dispensing](#)

Note: Should a pharmacist consult be required during Telepharmacy operations, contact the pharmacist at the Support Site (either before or during the “Inspection Call” for prescription verification), or contact an on-call pharmacist.

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Navy Pharmacy SOP: Telepharmacy Operations

4.1 Prescription Final Verification

Clinics, or Remote Sites, utilize Telepharmacy technology to contact the pharmacist at a Support Site to perform final verification of a medication before dispensing.

4.1.1 Prepare for Remote Pharmacist Final Verification

4.1.2 Transmit Telepharmacy Prescription

4.1.3 Perform Remote Pharmacist Final Verification

4.1.4 Prepare for Prescription Dispensing

To return to the Table of Contents, click [here](#).

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4.1.1 Prepare for Remote Pharmacist Final Verification

After completing the prescription filling procedures ([3.3 Prescription Filling](#)) and reviewing clinical warnings ([3.2.8 Review Clinical Warnings](#)), the pharmacy technician at the Remote Site prepares medications for remote verification by the Support Site pharmacist.

The following steps must be followed to prepare for remote pharmacist final verification:

- ✓ Open the Fill/Batch menu in the Telepharmacy terminal.
 - Note: The pharmacy technician at the Remote Site must conduct the entirety of this Process in the Fill/Batch menu of the Telepharmacy terminal.
- ✓ Scan stock medication barcode at the Telepharmacy terminal and verify prescription information that appears.
 - If the prescription is manually filled, capture the image for pharmacist review, to include the drug name, strength, lot number and expiration date.
 - Remove between one and three tablets/capsules from the medication bottle or package, place in the bottle cap or sterile trays, and capture the image so that the pharmacist can view the image of the actual medication.
 - If the medication is a liquid or prepackaged, and tablets/capsules cannot be counted out, capturing the image of the bottle or packaging information from the original medication bottle is sufficient.
- ✓ Scan and capture the image of the hard copy prescription OR Composite Health Care System (CHCS) label containing prescription information.
- ✓ Print prescription label and capture image for pharmacist review.
- ✓ Repeat this process until all of the patient's prescriptions requiring pharmacist verification are scanned and all images have been captured.
- ✓ Save all images to the patient's ScriptPro medication profile.

Once all images have been saved, the pharmacy technician at the Remote Site may choose to repeat these steps for additional patients' prescriptions.

When the pharmacy technician is finished preparing prescriptions for the Support Site's pharmacist review, he or she must identify him or herself through the Telepharmacy terminal using his or her ScriptPro barcode ID or Common Access Card (CAC), depending on the specific Telepharmacy functionality available.

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4.1.2 Transmit Telepharmacy Prescription

Once the pharmacy technician at the Remote Site has prepared the prescription for verification, he or she places a verification call to the pharmacist at the Support Site using the ScriptPro Telepharmacy terminal. The Telepharmacy terminal at the Support Site alerts end users through a ring tone and the pharmacist selects “ACCEPT” on the monitor. The pharmacist and pharmacy technician will confirm both voice and visual connection so that they may communicate with one another about the pending prescriptions.

- If the Support Site cannot immediately accommodate the incoming Telepharmacy call, the pharmacist at the Support Site will have the option to place the call on hold by selecting “HOLD” on the monitor. This will notify the Remote Site that the call has been placed on hold.
 - To answer a call on hold, the pharmacist at the Support Site will select the “CALLS HOLDING” option on the monitor and choose which call to connect to.
- Depending on the level of workload and pharmacist availability, sites with a pharmacist available may divert verification workload using remote Telepharmacy verification.

Support Site Unavailable

If the Support Site is unresponsive to the verification calls and the Telepharmacy terminal is operable, the pharmacy technician at the Remote Site must wait until a pharmacist is available to dispense prescriptions. **Prescription verification using Telepharmacy technology may ONLY be performed by a pharmacist.**

If the reason the Support Site is unresponsive is that a pharmacist is not logged in to the Telepharmacy terminal, the Remote Site should call the Support Site by telephone to ask the pharmacist to log into the Telepharmacy terminal and set their status to “TAKING CALLS.”

If the Support Site is unresponsive because the Telepharmacy terminal is inoperable, the pharmacy technician must follow the procedures in [4.2.2 Telepharmacy Downtime Procedures](#).

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4.1.3 Perform Remote Pharmacist Final Verification

Clinics with Telepharmacy installed shall utilize remote pharmacist verification whenever an onsite pharmacist is unavailable.

The following steps must be followed to initiate remote pharmacist final verification:

- ✓ Open the Fill/Verify/Batch menu in the Telepharmacy terminal.
 - Prescriptions awaiting pharmacist verification will appear on the Support Site pharmacist's Telepharmacy monitor.
 - Note: The pharmacist at the Support Site must conduct the entirety of this Process in the Fill/Verify/Batch menu.
- ✓ The pharmacist selects a prescription for verification and confirms that the images are clear and readable.
 - If the images are not clear, the pharmacist shall ask the pharmacy technician to recapture the images, following the procedures included in [4.1.1 Prepare for Remote Pharmacist Final Verification](#).
- ✓ The pharmacist at the Support Site verifies the prescription following the procedures included in [3.4 Prescription Final Verification](#).
 - If the Support Site and the Remote Site share the same CHCS server, the pharmacist at the Support Site will be able to access the patient's CHCS profile as needed. If not, the pharmacist will communicate with the Remote Site for information related to the patient's CHCS profile.
- ✓ Once the prescription has been verified, the pharmacist indicates that verification is complete by identifying him or herself through the Telepharmacy terminal using his or her ScriptPro barcode ID or CAC, depending on the specific Telepharmacy functionality available.

These final verification steps are repeated until all prescriptions are verified. At that time, the pharmacist ends the Telepharmacy call with the Remote Site.

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4.1.4 Prepare for Prescription Dispensing

After the pharmacist at the Support Site has verified the prescriptions, the pharmacy technician at the Remote Site must perform the following steps for each patient:

- ✓ Select “BATCH ALL” to group all verified prescriptions
- ✓ Select “PRINT BARCODE”
- ✓ Affix printed barcode to the paper bag containing the patient’s prescriptions

The barcode may be printed and affixed to the paper bag earlier in the process to accommodate workload and facilitate organization of multiple patients’ prescriptions.

Navy Pharmacy SOP: Telepharmacy Operations

4.2 Prescription Dispensing

A prescription may only be dispensed once it has received its final verification. Telepharmacy technology is used at Remote Sites to provide any required pharmacist counseling and to indicate within ScriptPro that the prescription has been dispensed.

4.2.1 [Dispense Telepharmacy Prescription](#)

4.2.2 [Telepharmacy Downtime Procedures](#)

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Telepharmacy Operations

4.2.1 Dispense Telepharmacy Prescription

The processes and procedures for dispensing prescriptions included in [3.5 Prescription Dispensing](#) must be followed when the Remote Site dispenses a prescription; however additional, specific instructions for utilizing Telepharmacy technology during this phase are as follows:

- [Dispense Prescription in ScriptPro](#)
- [Provide Remote Patient Counseling](#)

Dispense Prescription in ScriptPro

For sites utilizing Telepharmacy verification, the following steps must be completed by the Remote Site in addition to those steps included in [3.5 Prescription Dispensing](#):

- ✓ Open the Will Call Manager menu in the Telepharmacy terminal.
 - Note: The pharmacy technician at the Remote Site must conduct the entirety of this Process in the Will Call Manager menu.
- ✓ The pharmacy technician scans the barcode on the patient's prescription bag.
- ✓ When the patient's prescription information appears on the monitor, the pharmacy technician asks the patient to sign the electronic pad to verify their receipt of the prescription. (Note: This step applies only to sites with access to an electronic pad.)
 - Should the patient request counseling at this time, refer to the [Provide Remote Patient Counseling](#) procedures.
- ✓ After providing the patient with their prescriptions, the pharmacy technician selects "DISPENSE" on the Telepharmacy monitor.
 - Note: This is separate from the "DRX" function within CHCS; "DRX" must still be performed within CHCS once the prescription has been dispensed to the patient.

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Provide Remote Patient Counseling

For Remote Sites, patients shall be offered the opportunity to receive counseling from a pharmacist at the Support Site via telephone or videoconference. All procedures included in [3.5.3 Perform Patient Counseling](#) still apply; the remote patient counseling procedures detailed below are additional and apply when the patient at the Remote Site elects to receive pharmacist consultation.

When a patient elects to receive remote counseling from a pharmacist, pharmacy staff shall comply with the following procedures:

- ✓ The pharmacy technician at the Remote Site will place a “COUNSELING CALL” to the pharmacist at the Support Site using the Telepharmacy terminal.
- ✓ Once the pharmacist is on the line and the technician has provided the necessary information to the pharmacist, the monitor and camera will be turned to face the patient and he or she will be instructed to pick-up the handset.
- ✓ During the call, the pharmacist will make appropriate documentation about the counseling discussion on the patient’s ScriptPro profile under “DISPENSING COMMENTS.”
- ✓ When the call is finished, the pharmacist will identify themselves through the Telepharmacy terminal using their ScriptPro barcode ID or CAC, depending on specific Telepharmacy functionality available, and disconnect the call.

For locations without privacy screens, or where the Telepharmacy terminal is located within the pharmacy, the patient should be informed that their privacy cannot be guaranteed. In these situations, pharmacy staff will offer patients an alternative, private area for counseling.

Navy Pharmacy SOP: Telepharmacy Operations

4.2.2 Telepharmacy Downtime Procedures

In addition to the downtime procedures provided in [3.0 Outpatient Pharmacy Operations](#), specific procedures must be followed during Telepharmacy downtime. If the pharmacy does not have the functionality to communicate, and Telepharmacy technology is non-operational, local Continuity of Operations Plan (COOP) procedures must also be followed.

In all downtime situations, the scope of services provided by the pharmacies utilizing Telepharmacy technology, including both Remote and Support sites, will be determined by Command capacity, patient population and the pharmacist's clinical and professional judgment.

During Telepharmacy downtime, there are restrictions on prescription dispensing and exceptions that allow a technician to verify some medications:

- When a pharmacist is unavailable to review a prescription and Telepharmacy is non-operational, site technicians should follow the standard procedures found in [3.4 Prescription Final Verification](#) for technician verification of prescriptions.
 - Only AHLTA-entered medications not deemed high-risk by Command policy may be dispensed during Telepharmacy downtime.
 - Only during Telepharmacy downtime may pharmacy technicians utilize the pharmacist verification function of the Telepharmacy system to dispense allowed medications. In these instances, a pharmacist must retrospectively review all prescriptions verified by a pharmacy technician.

5.0 BATCH REFILL PHARMACY OPERATIONS

The procedures stated within this Section of the Navy Pharmacy Standard Operating Procedure (SOP) apply to batch refill pharmacy operations. Batch refill pharmacy operations include the processing and filling of refill prescriptions that patients have submitted to the pharmacy remotely (i.e., through the use of the automated refill request system, AudioCare) for future pick-up.

Pharmacies may require patients to use automated refill request systems to request prescription refills.

There are two types of “Batch Refill Pharmacies:”

- *“Centralized Batch Refill Pharmacies:”* Commands that centralize refill operations at a single facility. A Centralized Batch Refill Pharmacy is designed to process and fill refill prescriptions for one or more pharmacies within their Command, and deliver these refill prescriptions to the designated pharmacy locations (“Batch Refill Dispensing Pharmacies”) for dispensing to patients.
 - An example of a Centralized Batch Refill Pharmacy is Scott Center (NMC Portsmouth). This facility processes refills for NBHC Boone, BMC Sewells Point, NBHC Oceana, and other NMC Portsmouth clinics.
- *“Independent Batch Refill Pharmacies:”* Pharmacies that individually complete the full scope of Batch Refill operations. These pharmacies differ from Centralized Batch Refill Pharmacies in that the refill prescriptions are processed, filled, and dispensed at the same pharmacy location.
 - An example of an Independent Batch Refill Pharmacy is NBHC Mayport (NH Jacksonville).
 - A Centralized Batch Refill Pharmacy may also operate as an Independent Batch Refill Pharmacy, in that the pharmacy may process, fill, and dispense refills in addition to processing and filling refills for other clinics.

A “Batch Refill Dispensing Pharmacy” is any pharmacy that dispenses batch refills, regardless of whether they are an Independent Batch refill Pharmacy or use a Centralized Batch Refill Pharmacy. Patients retrieve their refill prescriptions from these pick-up locations.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

Six Critical Duties exist related to Batch Refill Pharmacy Operations:

- 5.1 [Batch Refill Processing](#)
- 5.2 [Batch Refill Filling](#)
- 5.3 [Batch Refill Final Verification](#)
- 5.4 [Batch Refill Delivery](#)
- 5.5 [Batch Refill Order Dispensing](#)
- 5.6 [AudioCare Downtime Procedures](#)

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.1 **Batch Refill Processing**

Batch Refill prescriptions are transferred from AudioCare to Composite Health Care System (CHCS) and processed through the use of both automation and manual filling processes. Batch Refill prescription processing involves reviewing clinical warnings, such as drug interactions and allergies, and making appropriate prescription edits.

5.1.1 **Process New Batch**

5.1.2 **Review Clinical Warnings**

5.1.3 **Correct Prescription Errors and Perform Edits**

5.1.4 **Print Batch Labels**

Note: Several components of Batch Refill Processing correlate with outpatient procedures and are identified as such.

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.1.1 Process New Batch

Patients requesting prescription refills submit their requests using the AudioCare automated refill system. Once the request is submitted, the refill prescription information is automatically transferred into CHCS for processing by pharmacy staff.

The Batch Refill Pharmacy will identify pending refill requests within CHCS for batch processing. The CHCS “PRESCRIPTIONS IN SUSPENSE REPORT” (PSR) function allows pharmacy staff to identify refill requests that have transferred into CHCS from AudioCare.

- To verify that all prescription refill requests have been successfully transferred into CHCS, the Batch Refill Pharmacy may utilize the “RE-QUEUE POSTING ERRORS” function within the AudioCare system to identify entries that did not originally post to CHCS and manually transfer these prescriptions to CHCS.
 - Note: Prescriptions may not have transferred due to AudioCare downtime. Check the AudioCare “SYSTEM STATUS” to determine the cause of the posting error.

5.1.2 Review Clinical Warnings

CHCS will conduct a drug warning check and verification against a patient’s known allergies and current medication list.

Note: When a pharmacist is present, clear clinical warnings before printing batch labels (“BPL”). Otherwise, clinical warnings may be cleared after printing.

Pharmacy staff will review all refill prescriptions to identify prescriptions with a status indicating that a clinical warning review is required:

- If a clinical warning presents, pharmacy staff may choose to override the warning.
 - Clinical warnings must be reviewed for all outpatient medication orders. Review of clinical warnings must include a drug warning review and a review of allergy, duplicate medication, drug class warnings, and drug interactions.
- Pharmacy staff will ensure any refills not able to be processed due to an unresolved clinical warning are “credited back” to the patient through CHCS.

Refer to [3.2.8 Review Clinical Warnings](#) for the procedures and steps required for reviewing clinical warnings prior to refilling the prescription.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.1.3 Correct Prescription Errors and Perform Edits

Should the refill prescription require any non-clinical edits, pharmacy staff will follow one of the subsequent procedures:

- ✓ Create a new prescription within CHCS and follow the subsequent procedures:
 - Reference the old prescription number in the “PRESCRIPTION COMMENTS” field
 - Discontinue any remaining refills for the old prescription from CHCS
 - Process the refill under the new prescription OR
- ✓ Use the Modify Active Prescription (“MAP”) function within CHCS to edit the prescription

Should a refill prescription require clinical edits, pharmacy staff will consult with the provider.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.1.4 Print Batch Labels

Pharmacy staff will print batch labels according to the following procedures:

- ✓ If refill requests were transferred into CHCS while pharmacy staff was clearing clinical warnings, follow the procedures in [5.1.2 Review Clinical Warnings](#) to prepare these prescriptions for processing.
- ✓ Print labels for all refill requests in preparation for filling
 - The “BATCH PRINT LABELS” (BPL) option under the CHCS “PRESCRIPTIONS MENU” enables pharmacy staff to complete this procedure.
 - Orders are filled on a first-come, first-filled basis. Pharmacy staff may override this prioritization and manually prioritize orders in the system as appropriate.
 - Batch refill labels will be printed at a designated refill printer, or sent to automation, as appropriate.

Note: The Batch Refill Pharmacy shall download pending refill prescriptions for further processing and printing of batch labels as determined by local need. However, it is recommended that pharmacy staff coordinate the downloading and printing of batch refill medications in smaller quantities to reduce the incidence of equipment malfunction and lost work. This process may be performed as frequently as workload and workflow permits.

To be completed by the Command:

Our local command downloads pending refill prescriptions and prints batch labels every:

Please indicate above the frequency with which your pharmacy downloads pending refill prescriptions for further processing and printing of batch labels.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.2 **Batch Refill Filling**

Frequently dispensed, “fast mover” refill medications are often filled by automated systems, whereas infrequent, compounded, and prepackaged medications are often filled manually.

Refer to [3.3 Prescription Filling](#) for the procedures and steps required by the Batch Refill Pharmacy to complete this process.

- Note: Prescriptions that have been filled and await final verification shall be placed in patient-specific containers (i.e., bins or bags).

5.2.1 **Not in Stock (NIS) Medications**

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.2.1 Not in Stock (NIS) Medications

Refill requests for medications that are “not in stock” (NIS) in the Centralized Batch Refill Pharmacy, and are to be picked up by the patient at a Batch Refill Dispensing Pharmacy that performs prescription filling operations, will typically be filled at the Batch Refill Dispensing Pharmacy; however exceptions can be coordinated between pharmacy leadership at the two pharmacies.

Pharmacy staff at the Centralized Batch Refill Pharmacy will communicate with pharmacy staff at the Batch Refill Dispensing Pharmacy to ensure that the prescription is filled. Pharmacy staff at the Batch Refill Dispensing Pharmacy shall communicate with the patient to alert them to any delay in their medication pick-up schedule.

Refer to [5.3.1 Centralized Batch Refill Pharmacy Prescription Bag Preparation](#) and [5.5.1 Receive Refill Prescriptions](#) for additional information related to NIS situations.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.3 Batch Refill Final Verification

Refill prescriptions may be checked by either a pharmacist or a pharmacy technician in accordance with current Joint Commission guidelines. It is required, however, that the filling technician not be the same pharmacy staff member as the final verification technician.

Refer to [3.4 Prescription Final Verification](#) for the procedures and steps required to perform prescription final verification.

5.3.1 Centralized Batch Refill Pharmacy Prescription Bag Preparation

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.3.1 Centralized Batch Refill Pharmacy Prescription Bag Preparation

For refills processed at a Centralized Batch Refill Pharmacy for future delivery to Batch Refill Dispensing Pharmacies, each patient prescription bag must be clearly labeled with the name of the Batch Refill Dispensing Pharmacy for which the patient prescription bag is intended.

The following instances require additional labeling be included in, or affixed to, the patient's prescription bag, following final verification of the prescription:

- *Cold Chain Items*: Medications requiring refrigerated storage must be contained in bags clearly identifiable as cold chain items.
 - Refer to [5.4.1 Batch Refill Prescriptions](#) for further information regarding proper delivery of cold chain items.
- *Controlled Substances*: At pharmacies where a signature is required for Schedule-III-V prescriptions, prescription bags containing controlled substances must include a sheet, to include all prescription label information, for the patient to sign and date upon prescription dispensing to acknowledge receipt of the prescription.
 - Note: Sites that utilize an electronic signature pad may document the patient's signature via electronic signature, in place of the hard copy controlled substances sheet.
- *Not in Stock (NIS)*: Refill requests for medications that are NIS in the Centralized Batch Refill Pharmacy, and are determined to instead be filled at the Batch Refill Dispensing Pharmacy that performs prescription filling operations, are designated as such by a note attached to the patient's prescription bag.
 - The note will include the original label of the medication which is NIS in the Centralized Batch Refill Pharmacy, an explanation as to why the medication is NIS (e.g., back-order, non-formulary item), and when the pharmacy expects to receive the medication back in stock.
 - Refer to [5.5.1 Receive Refill Prescriptions](#) for additional information related to refill requests that are NIS.
 - Note: If the Batch Refill Dispensing Pharmacy does not perform prescription filling operations, the Centralized Batch Refill Pharmacy will maintain responsibility for filling the prescription. In these instances, the Centralized Batch Refill Pharmacy will coordinate with the Batch Refill Dispensing Pharmacy to notify the patient as to the change in prescription processing time and any additional steps the patient may need to take (e.g., request their provider change their medication, have their prescription filled at a civilian pharmacy).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

- *Unresolved Drug Interaction Warnings:* Drug interaction warnings are included in the patient's prescription bag to alert the Batch Refill Dispensing pharmacy staff to the warnings
 - Instructions for pharmacy staff at the Batch Refill Dispensing Pharmacy for unresolved drug interaction warnings are affixed to the bag when needed. The Centralized Batch Refill Pharmacy should attempt to resolve all warnings with the patient and/or provider within the refill processing time.

Following final verification of the medications in a patient's prescription bag, the bag is sent to a sorting area where pharmacy staff sorts the prescriptions into the clinic-specific totes, as appropriate, for delivery.

- Independent Batch Refill Pharmacies will store refills in a designated area of the pharmacy prior to dispensing.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.4 Batch Refill Delivery

Following final verification, Batch Refill prescriptions are prepared for dispensing. Different processes apply depending on whether the prescriptions were batched at a Centralized Batch Refill Pharmacy or an Independent Batch Refill Pharmacy.

- For prescriptions batched at an Independent Batch Refill Pharmacy, prescriptions are dispensed following the procedures found in [5.5.2 Dispense Refill Prescriptions](#) and [3.5 Prescription Dispensing](#).
- For prescriptions batched at a Centralized Batch Refill Pharmacy, prescriptions are prepared for transit, transferred, and delivered to the appropriate site(s) for dispensing following the procedures included below:

5.4.1 Batch Refill Prescriptions

5.4.2 Deliver Batch Refill Prescriptions

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.4.1 Batch Refill Prescriptions

Processes for batching and preparing refill prescriptions for delivery vary depending on the delivery method used by the Centralized Batch Refill Pharmacy:

- [Local Delivery by Pharmacy Personnel](#)
- [Courier Delivery](#)
- [Shipping Service Delivery](#)

Note: For all delivery methods, medications requiring refrigeration should be packaged and delivered according to the procedures outlined for [Cold Chain Items](#).

Local Delivery by Pharmacy Personnel

The Command may choose to utilize pharmacy personnel to deliver refill prescriptions from the Centralized Batch Refill Pharmacy to local Batch Refill Dispensing Pharmacies (e.g., a refill center located on the same base). In these instances, certain procedures must be followed:

- ✓ The pharmacy will establish, in coordination with the Command, procedures for using Command vehicles for refill delivery.
 - Note: Personal vehicles may not be used for the transportation of medication, unless directly authorized by local policy.
- ✓ The Centralized Batch Refill Pharmacy Department Head may generate a memorandum stating which personnel are permitted to transport medication from the Centralized Batch Refill Pharmacy to designated Batch Refill Dispensing Pharmacies.
 - A copy of this memorandum must be kept on file at the Centralized Batch Refill Pharmacy, as well as carried by the authorized personnel during deliveries.
 - Refer to [Appendix E – Pharmacy Forms and Templates](#) for the “Pharmacy Personnel Authorized to Transport Medication” memorandum.
- ✓ Prescription bags must be clearly labeled with the appropriate Batch Refill Dispensing Pharmacy name.
 - Note: Refrigerated prescriptions must be clearly identifiable as cold chain items. Refer to [Cold Chain Items](#) for further information regarding proper delivery of refrigerated medications.

If applicable, the Pharmacy Department head is responsible for ensuring that the Command policy on the transportation of refill medications by local pharmacy personnel is provided. Please embed your Command policy below.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

Courier Delivery

The Pharmacy Department may make arrangements for a courier to transport batch refills from the Centralized Batch Refill Pharmacy to the appropriate Batch Refill Dispensing Pharmacies. All refill prescriptions must be batched and prepared for delivery according to the following procedures:

- ✓ Transport all sealed prescription bags to the loading area and collect clinic totes for filling.
- ✓ Pharmacy staff is responsible for sealing the collection totes prior to transportation to the loading area.
- ✓ Sort all prescription bags by destination and place each batch of prescriptions in the designated tote.
- ✓ If the batch refill order includes refrigerated prescriptions, pharmacy staff will remove all refrigerated prescriptions from the holding refrigerator, sort the prescription bags by destination and place each batch of refrigerated prescriptions in the designated tote.
 - Note: Refrigerated prescriptions must be clearly identifiable as cold chain items. Refer to [Cold Chain Items](#) for further information regarding proper delivery of refrigerated medications.
- ✓ Secure each side of the tote using a plastic tag with a unique serial number
- ✓ Record the plastic tag's serial number, tote destination, and container type in the Batch Refill Delivery Log.
 - A Batch Refill Delivery Log entry shall be completed for each tote. Refer to [Appendix E – Pharmacy Forms and Templates](#) for the Batch Refill Delivery Log.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

Shipping Service Delivery

Centralized Batch Refill Pharmacies that send refill prescriptions to Batch Refill Dispensing Pharmacies through a commercial shipping service (e.g., FedEx, UPS) will adhere to the following procedures:

- ✓ A single delivery tracking number shall be applied to all packages being delivered to the same Batch Refill Dispensing Pharmacy.
- ✓ The pharmacy staff member who ships the packages will select to require a signature upon receipt of the delivery.
- ✓ Refrigerated medications may not be shipped if the shipping service cannot guarantee appropriate refrigeration accommodations throughout the shipping cycle. In these instances, the Centralized Batch Refill Pharmacy will coordinate to have the Batch Refill Dispensing Pharmacy fill the prescription directly, or to determine an alternate delivery plan.
 - Note: Refer to [Cold Chain Items](#) for further information regarding proper delivery of refrigerated medications.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

Cold Chain Items

Medications requiring refrigeration are delivered in a temperature-controlled supply chain. For all delivery methods, cold chain items should be packaged and stored according to the following instructions:

- ✓ Clearly label all refrigerated prescriptions as cold chain items.
- ✓ Store cold chain items in a holding refrigerator, within the Centralized Batch Refill Pharmacy, until such time as they are transferred to the appropriate delivery container.
 - Note: Cold chain items should be stored in a clear plastic bag within the refrigerator, to prevent medication damage from condensation.
- ✓ Remove all cold chain items from the holding refrigerator.
- ✓ Sort the prescription bags by destination and place each batch of cold chain items in the appropriate, insulated delivery container.
- ✓ To maintain the necessary level of refrigeration during transit, carefully surround prescription bags with ice packs within the delivery container, taking care to ensure that the ice packs do not directly touch prescription bags.
 - Note: If utilizing either Courier Delivery or Shipping Service Delivery, pharmacy staff must communicate with the Courier/Shipping Service to ensure that cold chain items are stored in a holding refrigerator, if not immediately delivered to the Batch Refill Dispensing Pharmacy.

For patients presenting with prescriptions for cold chain and non-refrigerated items simultaneously, pharmacy staff should clearly indicate on the non-refrigerated prescription bag that the prescription also includes refrigerated items.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.4.2 Deliver Batch Refill Prescriptions

Batch refill prescriptions are delivered from the Centralized Batch Refill Pharmacy to the appropriate Batch Refill Dispensing Pharmacies based on the volume and frequency demands as determined by local needs.

For Commands utilizing local courier services, the courier will retrieve empty totes from the Batch Refill Dispensing Pharmacies during the next delivery for use in future deliveries.

Note: It is recommended that pharmacy staff coordinate daily collection and delivery of batch refill medications; however the precise transportation policy and delivery schedule is to be determined by the Command.

The Pharmacy Department Head is responsible for ensuring that the Command's transportation policy and delivery schedule is provided. Please embed your Command policy below.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.5 Batch Refill Order Dispensing

Once refill prescriptions are delivered to the Batch Refill Dispensing Pharmacy, they are dispensed to the patient following patient counseling or held for patient pick-up. If the patient fails to pick-up their refill medication after a maximum of **14 calendar days**, it is returned to stock (RTS) by Batch Refill Dispensing pharmacy staff. Pharmacy staff will ensure that patients are credited with a refill within CHCS for any refill that is returned to stock.

5.5.1 Receive Refill Prescriptions

- Not applicable to Independent Batch Refill Pharmacies.

5.5.2 Dispense Refill Prescriptions

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.5.1 Receive Refill Prescriptions

Note: “Receive Refill Prescriptions” is not applicable to Independent Batch Refill Pharmacies. For prescriptions batched at an Independent Batch Refill Pharmacy, prescriptions are dispensed following the procedures found in [5.5.2 Dispense Refill Prescriptions](#) and [3.5 Prescription Dispensing](#).

- *Missing Refill*: In cases in which a refill prescription is delivered to the wrong pharmacy, the Batch Refill Dispensing Pharmacy staff record the error on the Missing Refill Report (refer to [Appendix E – Pharmacy Forms and Templates](#) for the Missing Refill Report) and alert the pharmacy for which the prescription was intended. **Pharmacy staff at the correct location will then process a one-time refill order for the patient.**

Note: The purpose of the Missing Refill Report is to report and document the instances of missing refills, not to mitigate the issue.

- The pharmacy that erroneously received the prescription will either add the medication to their inventory, or return it to the Centralized Batch Refill Pharmacy in the Return to Stock tote.
- If the correct Batch Refill Dispensing Pharmacy does not provide prescription filling services, pharmacy staff will coordinate with the Centralized Batch Refill pharmacy to either receive the erroneously-delivered prescription or a new prescription.
- When necessary, pharmacy staff will notify the patient as soon as possible as to the change in prescription processing time and any additional steps the patient may need to take (e.g., request their provider change their medication, have their prescription filled at a civilian pharmacy).
- Batch Refill Dispensing Pharmacies will deliver a Missing Refill Report to the Centralized Batch Refill Pharmacy on a weekly basis, at a time to be determined by the Pharmacy Department.
- The Pharmacy Department Head at the Centralized Batch Refill Dispensing Pharmacy is responsible for coordinating with the Department Heads at the Batch Refill Dispensing Pharmacies to identify trends in Missing Refills and resolve recurring issues.
- *Not in Stock (NIS) item*: If a medication for a refill request is NIS at the Centralized Batch Refill Pharmacy, and the refill request is to be picked up at a Batch Refill Dispensing Pharmacy that performs prescription filling operations, the Batch Refill Dispensing Pharmacy will process the request as **a one-time refill order**.
 - If the refill prescription is also NIS at the Batch Refill Dispensing Pharmacy, pharmacy leadership at the two pharmacies will coordinate to determine the appropriate pharmacy to maintain responsibility for filling the prescription.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

- When necessary, Batch Refill Dispensing Pharmacy staff will notify the patient as to the change in prescription processing time and any additional steps the patient may need to take (e.g., request their provider change their medication, have their prescription filled at a civilian pharmacy).

Processes for receiving refill prescriptions vary depending on the delivery method used by the Centralized Batch Refill Pharmacy:

- [Local Delivery by Pharmacy Personnel](#)
- [Courier Delivery](#)
- [Shipping Service Delivery](#)

Local Delivery by Pharmacy Personnel

Pharmacy staff delivering the refill prescriptions will coordinate with pharmacy staff at the Batch Refill Dispensing Pharmacy for delivery receipt.

Courier Delivery

The Batch Refill Dispensing Pharmacy will indicate receipt of the refill delivery from the Centralized Batch Refill Pharmacy via the courier according to the following procedures:

- ✓ The Batch Refill Dispensing Pharmacy will sign for the delivery on the Batch Refill Delivery Log to indicate that the appropriate totes and prescriptions arrived sealed and intact.
- ✓ The Batch Refill Dispensing Pharmacy will make a copy of the signed form, to be filed in the pharmacy for a minimum of 30 days, and return the original form via the courier, or electronically.
 - The Centralized Batch Refill Pharmacy will review the completed Batch Refill Delivery Log and file it in the pharmacy for a minimum of 30 days.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

Shipping Service Delivery

The Batch Refill Dispensing Pharmacy will indicate receipt of the refill delivery from the Centralized Batch Refill Pharmacy via the shipping service's signature requirement. The Batch Refill Dispensing Pharmacy is responsible for reviewing the contents of all shipments for any issues that would compromise the safety or integrity of the medication. If any issues are identified, the Batch Refill Dispensing Pharmacy will communicate them to the Centralized Batch Refill Pharmacy, and the two sites will coordinate to address the issues.

Refill prescriptions that have been delivered are stored in the Batch Refill Dispensing Pharmacy prior to dispensing. Commands may choose to alert patients that their refill is ready for pick-up through use of the automated refill call-in system (AudioCare).

For further assistance with AudioCare functionality, refer to the information found in [7.6.1 Manufacturer Contact Information](#).

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.5.2 Dispense Refill Prescriptions

The Batch Refill Dispensing Pharmacy dispenses refill medications following the procedures found in [3.5 Prescription Dispensing](#).

Pharmacy staff shall regularly monitor dispensing shelves to review prescriptions that have not yet been picked up by patients. Refills that are not picked up after **14 calendar days** are either:

- Added to the Batch Refill Dispensing Pharmacy's inventory (if medication is actively stocked within the pharmacy) OR
- Returned to the Centralized Batch Refill Pharmacy

Patients will not be penalized a refill due to failure to pick up their prescription. All medications returned to stock must be annotated in the CHCS "PRESCRIPTION COMMENTS" field with "RTS." Refer to the [Non-Compliance Report](#) procedures for instructions on identifying prescriptions that need to be returned to stock.

Batch Refill Dispensing Pharmacies who return medication to a Centralized Batch Refill Pharmacy will send a "Return to Stock" tote to the Centralized Batch Refill Pharmacy via the courier on a weekly basis at minimum.

Non-Compliance Report (NCR)

Pharmacy staff may utilize the CHCS "NONCOMPLIANCE REPORT" (NCR) to identify prescriptions that have not yet been picked up by patients and need to be returned to stock.

Non-compliance indicates that a patient has failed to pick up their prescription within 14 calendar days. In order to indicate the prescription is being returned to stock, pharmacy staff may either:

- Manually mark the prescription as noncompliant, using the following menu path:
 - OPM → PM → SPM → NON

Note: ^NON may also be used as a shortcut to skip the above menu path

OR

- Set CHCS outpatient site parameters to establish automatic non-compliance of prescriptions, using the following menu path:
 - SFM → OMM → SIT → Select Outpatient Pharmacy Site
 - Edit the outpatient site parameters according to the following parameters:
 - Warning Grace Period: 10

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

- Pickup Grace Period: 14
- Exclude from Automated Noncompliance Process: NO

Note: ^SIT may also be used as a shortcut to skip the above menu path when accessing the outpatient site parameters.

Pharmacy staff may choose to set up AudioCare to call patients at the indicated “Warning Grace Period” to notify them if they have not yet picked up their refill. The automated system will contact the patient to inform them that a prescription is at the pharmacy waiting to be picked up and will be returned to stock on the grace period date.

Navy Pharmacy SOP: Batch Refill Pharmacy Operations

5.6 AudioCare Downtime Procedures

During AudioCare downtime, pharmacies shall follow procedures included in [3.0 Outpatient Pharmacy Operations](#) and [4.0 Telepharmacy Operations](#) for refill prescription filling.

Commands that are affected by AudioCare downtime must communicate to all Batch Refill Dispensing Pharmacies that refill delivery schedules may be delayed **and the delays should be communicated to patients**. Additionally, pharmacy staff will direct patients requesting a refill to either request refills in person or by calling a non-automated refill request line.

Navy Pharmacy SOP: Supply Operations

6.0 SUPPLY OPERATIONS

The procedures stated within this Section of the Navy Pharmacy Standard Operating Procedure (SOP) apply to supply operations. Pharmacy staff will follow these procedures when executing standardized pharmacy inventory management tasks.

Three Critical Duties exist related to supply operations:

6.1 [Manage Pharmacy Supply](#)

6.2 [Manage PVP Returns and Credits](#)

6.3 [Manage MMQC Drug Recalls](#)

6.4 [Manage Drug Shortage](#)

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Navy Pharmacy SOP: Supply Operations

6.1 Manage Pharmacy Supply

The Defense Medical Logistics Standard Support (DMLSS) System Administrator (SA) is responsible for the assignment of roles and privileges for the pharmacy site's DMLSS program. The DMLSS SA can assign pharmacy staff with the following privileges upon request:

- User Privilege Assignment
- Quality Assurance (QA) Pending Actions Privilege
- Customer Area Inventory Management (CAIM) Credit Returns Privileges



[MM02.01.01/7](#)
[MM02.01.01/10](#)
[MM02.01.01/14](#)
[MM03.01.01/2](#)
[MM05.01.17/3](#)
[MM05.01.17/4](#)

Pharmacy supply staff shall ensure that all supplies required for efficient and effective pharmacy operations are available and medications are stored according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Medications must be U.S. Food and Drug Administration (FDA) or Investigational Device Exemption (IDE) Institutional Review Board (IRB) approved drugs.

When a medication is recalled or discontinued for safety reasons by the manufacturer or the FDA, pharmacy staff shall follow procedures found in [6.3.1 Review Inventory Management Drug Recalls](#). The Pharmacy Department Head is responsible for notifying risk management, providers, hospital staff, and patients of the required actions to mitigate possible harm (as appropriate). The Pharmacy will communicate medication shortages and outages to medical staff via CHCS and other means.

When non-formulary medications are approved for use, pharmacy staff should follow command-approved processes for procuring these medications. Examples of processes for systematically procuring non-formulary medications can include use of a local or civilian pharmacy.

Quantities maintained shall be consistent with usage rates in order to ensure frequent turnover. Pharmacy supply shall utilize an up-to-date reference file of products and will prepare and review all government procurement documents necessary to maintain adequate stocking levels in the pharmacy. In addition, supply staff shall order best priced listed on the Mandatory National Contract and utilize Defense Logistics Agency (DLA) tools such as the Best Pharm Report.

Navy Medicine officials who place Pharmacy Prime Vendor (PV) orders must follow "[Ordering Officer Requirements Guide for Defense Logistics Agency \(DLA\) Ecommerce Contracts](#)" available on NKO. All Ordering Officers must be appointed by an approved Authorizing Official (AO) using the SF 1402. The SF 1402 must specify the PV pharmacy contracts and the maximum dollar limitations of orders. The Ordering Officer's maximum dollar limitation may not be greater than the authority delegated to the Appointing Official. A copy of the SF 1402 can be accessed on the [Federal Acquisition Regulation \(FAR\) website](#).

Ordering Officers must complete the following minimum training requirements prior to appointment:

- Defense Acquisition University (DAU) on-line course, Simplified Acquisition Procedures (CLC 005)

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- Note: A DAU introductory contracting or purchasing course (CON 090, CON 100, or CON 237) may be substituted.
- Introductory training on the Defense Medical Logistics Standard System (DMLSS)
- Orientation on specific contract ordering procedures (ECAT or PV); this orientation may be provided in a formal training setting or by reading [6.0 Supply Operations](#) in the Bureau of Medicine and Surgery (BUMED) Navy Pharmacy Standard Operating Procedure (SOP).
- DoN annual ethics training and file a completed OGE 450, found here: <http://www.oge.gov/Forms-Library/OGE-Form-450--Confidential-Financial-Disclosure-Report/>

Once completed, the newly-appointed Ordering Officer shall maintain the original copies of all documentation in the appointment package, which consists of the original SF 1402 and any associated supporting materials (training certificates, copy of filed OGE450, etc.). The Ordering Officer shall also forward a copy of the appointment package to the Contracting Shop and to the DMLSS SA. The appointment package must be retained for at least six years and three months past the date the Ordering Officer's position is no longer active. However, pursuant to the 05 October 2011 SECNAV Memorandum and 02 December 2011 BUMED Memorandum titled "[Immediate Retention of All Documentation to Support Current and Future Department of the Navy Financial Audits](#)", effective immediately and until further notice, retain all documentation in support of a financial statement audit indefinitely.

6.1.1 [Conduct Inventory Control](#)

6.1.2 [Establish and Modify Stocking Levels](#)

6.1.3 [Procure and Order Pharmacy Supply](#)

6.1.4 [Receipt Pharmacy Supply Order](#)

6.1.5 [Manage DMLSS Catalog](#)

To return to the Table of Contents, click [here](#).

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6.1.1 Conduct Inventory Control

Each pharmacy has a unique DMLSS Customer ID (e.g., DAAxxx).

An updated inventory is generated each time an item is ordered using Shelf Count Logic. During the replenishment process, pharmacy staff shall input the current inventory level which will generate the specific order quantity based on stocking level, reorder point, and due-ins.

The steps for establishing Shelf Count as the ordering method are:

- ✓ Select the **System Services Module**
- ✓ Click **Search**
- ✓ Type in **DAA** in the ID field
- ✓ Click **Search**
- ✓ Highlight specific **Pharmacy Customer**
- ✓ Click **Detail**
- ✓ Select **Materiel** tab
- ✓ Inventory Method should be set to **Shelf Count**
- ✓ Click **Save**

The screenshot shows the 'DMLSS System Services - [Service/Customer Detail - DAA000 - PHARMACY YUMA]' window. The 'Materiel' tab is selected. The 'Inventory Method' is set to 'Shelf Count'. The 'Days' field is set to 10 and the 'Inv Freq' field is set to 4. The 'Authorized Source of Supply' table is visible at the bottom.

SOS Code	Customer ID	SOS Type	SOS Name
001		NON-CONTRACTED	TIMEMED
002		NON-CONTRACTED	REES SCIENTIFIC CORP.
005		NON-CONTRACTED	MED REPAIR
006		NON-CONTRACTED	KMZ INCORPORATED
007		NON-CONTRACTED	OHMEDA MED

Figure 6.1.1-1: Shelf Count Customer Detail Screen

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The steps for setting Days of Stock as the computation method are:

- ✓ Select the **System Services** Module
- ✓ Click **Search**
- ✓ Type in **DAA** in the **ID field**
- ✓ Click **Search**
- ✓ Highlight specific **Pharmacy Customer**
- ✓ Click **Detail**
- ✓ Select **Materiel** tab
- ✓ Computation Method should be set to **Days of Stock** and Days field should be set to appropriate number for the pharmacy site level
- ✓ Click **Save**

Pharmacy supply staff shall determine Days of Stock based on the level of care, prescription workload, and overall mission.

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6.1.2 Establish and Modify Stocking Levels

The leveling module enables pharmacy staff to examine and modify individual item levels when necessary. Adjusting levels helps to maximize item availability and minimize inventory costs.

There are three Level Types that can be set for individual items:

- ✓ **Core:** All items set to core will have the DMLSS system automatically adjust the Level and ROPs as part of the End-Of-Month process with no pharmacy supply staff review.
- ✓ **Non-Stocked:** Items with no established Level or Reorder Point (ROP). Typically, these are one-time purchases. Non-stocked items must be purchased via Off-line Submit for Shelf Count Customers.
- ✓ **Static:** Pharmacy staff has the ability to review all recommended changes to the Level Type, Level and ROPs for each item and then Accept, Modify or Delete. (After 90 days of consumption, the system will provide recommended level changes per a customer pending action).

Note: All Navy Pharmacy customer active items will be set to Static.

For further information on setting up and maintaining the DMLSS catalog, refer to the information below:

- [Set and/or Update Levels and ROPs](#)
- [Non-Stock or Delete Items](#)
- [Add a New Item](#)
- [Print Barcodes](#)

Set and/or Update Levels and ROPs

All stocked pharmaceuticals shall be set to static, and appropriate levels and ROPs shall be established. Levels are equivalent to stocking or requisition objectives. The level represents the quantity that the pharmacy stocks on the shelf to meet level of care, prescription workload and mission.

ROPs represent the inventory quantity that an item must reach before a new order can be generated for that item. When building an order, supply staff should only scan items on the shelf that are at 50% or less of the established level to generate their order.

Note: Within DMLSS, a ROP should be set at one below the level (e.g. Level = 4, ROP = 3) to mitigate replenishment exceptions.

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The steps for setting Levels are (see Figure 6.1.2-1):

- ✓ Select the **Customer Area Inventory Management (CAIM)** module
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Cat Search**
- ✓ Type the National Drug Code (NDC) or drug name in the **Description** field (Search Tab)
- ✓ Click **Search** on vertical toolbar
- ✓ Click **Cust Detail** after catalog search result is highlighted
- ✓ Click **Edit**
- ✓ Select **Level Type** (e.g. static for all stocked items with Level ≥ 1)
- ✓ Click **Save**
- ✓ Click **Close**

Updating or editing a Level and/or ROP will prompt DMLSS to print new barcodes. The user may choose to print individual barcodes or print out all catalog updates in one batch. Refer to [Print Barcodes](#) for additional information.

Item ID: 00029152725

Customer Item Desc: EACTROBAN 2% CRM 30GM

Location: TOPICALS

Storage Area:

Expense Center: 68094XDAAA4

Est. Monthly Usage:

Level: 24

ROP: 23

Level Type:

- ☐ Core
- ☒ Static
- ☐ Non-Stocked

Resale Indicator: ☐

ORMA Indicator: ☐

Point Of Use: ☐

Carousel: ☐

Ready Use: ☐

Marked for Deletion: ☐

Consumption

AUG 2012	JUL 2012	JUL 2012	JUN 2012	MAY 2012	APR 2012	APR 2012	MAR 2012	FEB 2012	JAN 2012	DEC 2011	NOV 2011	OCT 2011	OCT 2011	SEP 2011	AUG 2011	JUL 2011	JUN 2011	MAY 2011	APR 2011
36	24	0	0	0	0	108	0	0	0	0	0	0	24	0	24	0	0	0	0

Figure 6.1.2-1: Catalog Level Set-Up Screen

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The steps for updating Levels and ROPs are:

- ✓ Select **the Customer Area Inventory Management (CAIM) module**
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Cat Search**
- ✓ Type the NDC or drug name in the **Description** field (Search Tab)
- ✓ Click **Search** on vertical toolbar
- ✓ Click **Cust Detail** after catalog search result is highlighted
- ✓ Click **Edit**
- ✓ Click **Static**
- ✓ Enter updated/new **Level** quantity
- ✓ Enter updated/new **Reorder Point (ROP)**
- ✓ Click **Save**
- ✓ Click **Close**

The steps for establishing or changing a drug item location are:

- ✓ Select **the Customer Area Inventory Management (CAIM) module**
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Cat Search**
- ✓ Type the NDC or drug name in the **Description** field (Search Tab)
- ✓ Click **Search** on vertical toolbar
- ✓ Click **Cust Detail**
- ✓ Click **Edit**
- ✓ Click **Add** to enter a new location
- ✓ Type new location in field
- ✓ Click **Save**

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Non-Stock or Delete Items

Items that are no longer required for use and do not need to be stocked within the pharmacy (e.g., items discontinued by a manufacturer) should be non-stocked or deleted from the Pharmacy's DMLSS catalog. Deleting an item or assigning an item to non-stocked automatically changes the Level and ROP to 0. This process facilitates effective catalog maintenance and provides greater oversight into the items that are actually stocked and ordered within the pharmacy.

The steps for non-stocking an item are (see Figure 6.1.2-2):

- ✓ Select the **Customer Area Inventory Management (CAIM) module**
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Cat Search**
- ✓ Type the NDC or drug name in the **Description** field (Search Tab)
- ✓ Click **Search** on vertical toolbar
- ✓ Click **Cust Detail**
- ✓ Click **Edit**
- ✓ Click **Non-Stocked**
- ✓ Click **Save**

The screenshot shows a software interface for managing inventory. The title bar reads 'DMLSS/CAIM - DAAA00/PHARMACY NMCP - [Item Location Detail -]'. The menu bar includes File, Edit, Data, Navigate, Utilities, Window, and Help. The toolbar contains icons for Cat Search, SOS, PC Status, Phys. Inva., Maint. Repl., Batch MNT, BarCode, BPS Order, Doc-In/Out, Issues, Receipts, Delivery List, Reports, Trans. Mntn..., and Check Pends. The main form area contains the following fields and controls:

- Item ID: 00029152725
- Customer Item Desc: BACTROBAN 2% CRM 30GM
- Location: DEFAULT (dropdown menu with an 'Add...' button)
- Storage Area: (empty dropdown menu)
- Expense Center: 001833DAA81 (dropdown menu)
- Est. Monthly Usage: (empty text field)
- Level: 0 (text field)
- ROP: 0 (text field)
- Level Type: Radio buttons for Core, Static, and Non-Stocked (Non-Stocked is selected)
- Resale Indicator: ☐
- DRMA Indicator: ☐
- Point Of Use: ☐
- Carousel: ☐
- Ready Use: ☐
- Marked for Deletion: ☐

On the right side, there is a vertical toolbar with icons for Save, Revert, Delete, Autosaved, Close, and Help Topics. The bottom section, labeled 'Consumption', displays 'no history available'.

Figure 6.1.2-2: Item Non-Stock Screen

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The steps for deleting an item are:

- ✓ Select the **Customer Area Inventory Management (CAIM) module**
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Cat Search**
- ✓ Type the NDC or drug name in the **Description** field (Search Tab)
- ✓ Click **Search** on vertical toolbar
- ✓ Click **Cust Detail**
- ✓ Click **Delete** on the vertical toolbar

The steps for undeleting an item are (see Figures 6.1.2-3 and 6.1.2-4):

- ✓ Select the **Customer Area Inventory Management (CAIM) module**
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Cat Search**
- ✓ Type the NDC or drug name in the **Description** field (Search Tab)
- ✓ Ensure that under **Scope (Customer Catalog)** that the **Active** and **Deleted** search fields are selected (see Figure 6.1.2-3)
- ✓ Click **Search** on vertical toolbar
- ✓ Click **Cust Detail**
- ✓ Click **Un-Delete** on the vertical toolbar (see Figure 6.1.2-4)
- ✓ Click **Edit**
- ✓ Click **Static**
- ✓ Enter updated/new **level quantity**
- ✓ Enter updated/new **ROP**
- ✓ Click **Save**
- ✓ Click **Close**

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DMLSS/CAIM - DAAA00/PHARMACY NMCP - [Catalog Search]

File Edit Data Navigate Utilities Window Help

☐ Cat Search
 ☐ SOS
 ☐ PC Status
 ☐ Phys. Inven.
 ☐ Maint. Repl.
 ☐ Batch MNT
 ☐ BarCode
 ☐ BPS Order
 ☐ Doc-In/Out
 ☐ Issues
 ☐ Receipts
 ☐ Delivery List
 ☐ Reports
 ☐ Trans. Mnt...
 ☐ Check Fields

Basic Search | **Advanced Search** | Categorical Search | Search Result Detail

Search By

Number: ☐ Starts With

Description:

Filter By

Pricing Agreement:

Scope

☐ Contracted Items
☐ Sourced Items
☐ Unsourced Items
☐ MTF Catalog
☐ LOG Catalog
☒ Customer Catalog

Cust. ID:

Active ☒ Deleted ☒

Item ID	Item Description	SOS	U/P	U/P Qty	U/P Price	U/S	U/S Price	U/M Price	EOH	Deleted	Manufacturer
00029152725	BACTROBAN 2% CRM 30GM	PVP	TU	30	50.65 TU		50.65	1.6883	0	Y	GLAXOSMITHKLINE

6.1.2-3: Deleted Item Search Screen

DMLSS/CAIM - DAAA00/PHARMACY NMCP - [Customer Catalog Detail - 00029152725]

File Edit Data Navigate Utilities Window Help

☐ Cat Search
 ☐ SOS
 ☐ PC Status
 ☐ Phys. Inven.
 ☐ Maint. Repl.
 ☐ Batch MNT
 ☐ BarCode
 ☐ BPS Order
 ☐ Doc-In/Out
 ☐ Issues
 ☐ Receipts
 ☐ Delivery List
 ☐ Reports
 ☐ Trans. Mnt...
 ☐ Check Fields

Item ID: Type Item ID:

Customer: SOS: Contract Type Code:

Short Item Desc: Product Group Code:

Cust Item Desc: PV Stocked: ☐

Local Field 1: Critical Item Ind: ☐

Local Field 2: Accept Equivalent Ind: ☐

Local Field 3: Marked for Deletion: ☒

Expiration Type: Shelf Life Months:

Hazmat: CAC:

Ordering Information

U/P: Unit:

U/P Quantity: U/M Quantity:

U/P Price: U/M Price:

Location	On Hand	Level	Resale	POU	CRSL	RU	ORMA	Del Ind	Pipeline Date	Days
DEFAULT	0	0							20 Sep 2002 08:48:32	2
									18 Oct 2002 09:59:30	2
									21 Feb 2003 10:53:06	2
									16 Mar 2003 12:34:23	4
									18 Apr 2003 08:40:04	2
									13 Jun 2003 10:28:23	2

6.1.2-4: Undelete Item Screen

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Add a New Item

When adding a new item to the DMLSS customer catalog, pharmacy staff must ensure that the item is a DoD contracted item. If applicable, staff must follow local command policy on who has the authority to add new items to a site's specific DMLSS customer catalog.

When adding a new item to the catalog that is a replacement for an item that has been discontinued, pharmacy staff must ensure that they non-stock or delete the old item out of their site's specific DMLSS customer catalog. Refer to [Non-Stock or Delete Items](#) for additional information.

One time or special buys should not be assigned a Level and should remain non-stocked.

The steps for adding an item to the DMLSS catalog are (see Figures 6.1.2-5-7):

- ✓ Select the **Customer Area Inventory Management (CAIM) module**
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Cat Search**
- ✓ Type the NDC or drug name in the **Description** field (Search Tab)
- ✓ Ensure that under **Scope** that **Contracted Items** search field is selected (see Figure 6.1.2-5)
- ✓ Select the correct item to be added to the Customer Catalog.
- ✓ Click **Add MTF** on the vertical toolbar (see Figure 6.1.2-6)
- ✓ Click **Cat Search**
- ✓ Type the NDC or drug name in the **Description** field (Search Tab)
- ✓ Click **Search** on vertical toolbar
- ✓ Click **Cust Cat Tab**
- ✓ Click **Add**
- ✓ **Edit** details in the record as appropriate (see Figure 6.1.2-7)
- ✓ Click **Save**

Navy Pharmacy SOP: Supply Operations

DMHSS/CAIM - DAAA00/PHARMACY NHCP - [Catalog Search]

File Edit Data Navigate Utilities Window Help

Car Search SOS PC Printer Phys Inven. Menu Right Batch MNT BrCode BPO Order Dev-to-Dev Screen Receipts Delivery List Reports Trace Note... Check Fields

Basic Search | Advanced Search | Categorical Search | Search Result Detail

Search By: Number Starts With ☐

Description: TOPRAMATE

Filter By: Pricing Agreement:

Scope:

- ☒ Contracted Items
- ☐ Sourced Items
- ☐ Unsourced Items
- ☐ MTF Catalog
- ☐ LOG Catalog
- ☐ Customer Catalog

Short Item Description SOS U/P U/P Qty U/P Price U/M Price LUM Pricing Agreement Number PA Type Item ID Standardized Prime Vendor Mi

6.1.2-5: Add Item Catalog Search

DMHSS/CAIM - DAAA00/PHARMACY NHCP - [Catalog Search]

File Edit Data Navigate Utilities Window Help

Car Search SOS PC Printer Phys Inven. Menu Right Batch MNT BrCode BPO Order Dev-to-Dev Screen Receipts Delivery List Reports Trace Note... Check Fields

Basic Search | Advanced Search | Categorical Search | Search Result Detail

Short Item Description: TOPRAMATE 25 MG TABLET UD 100S

Long Item Description: TOPRAMATE 25 MG TABLET UNIT DOSE 100S

Manufacturer: JHP

Manufacturer Catalog No.

NSN Vendor Item Number: 68084034211

NDC: 68084034211 GTIN:

Supplier Name: JMS PHARMACEUTICALS GROUP

Pricing Agreement No.: SP020005H9105 Pricing Agreement Type: CAT - STANDARD NONCONTRACT PHARM ITEM

Drop Ship Only: NO

Local Field 1:

Standardized: ☐

Scope:

- ☒ Contracted Items
- ☐ Sourced Items
- ☐ Unsourced Items
- ☐ MTF Catalog
- ☐ LOG Catalog
- ☐ Customer Catalog

Short Item Description SOS U/P U/P Qty U/P Price U/M Price LUM Pricing Agreement Number PA Type Item ID Standardized Prime Vendor

TOPRAMATE 25 MG TABLET UD 100S	PVP	EA	100	1.79	0179	N	SP020005H9105	CAT			DMSP
TOPRAMATE 25 MG TABLET UD 100S	PVP	EA	100	2.17	0217	N	SP020005H9105	CAT			DMSP
TOPRAMATE 25 MG TABLET 60S	PVP	EA	60	1.58	0263	N	SP020003H9104	CAT			DAKO
TOPRAMATE 25 MG TABLET UD 100S	PVP	CN	1000	29.68	0297	N	SP020003H9103	CAT			CARD
TOPRAMATE 25 MG TABLET 1000S	PVP	EA	1000	30.50	0305	N	VA797P0233	VNC			CARD
TOPRAMATE 25 MG TABLET 60S	PVP	EA	60	2.15	0358	N	VA797P0233	VNC			CARD
TOPRAMATE 100 MG TABLET UD 100S	PVP	CN	1000	41.75	0418	N	SP020003H9103	CAT			CARD
TOPRAMATE 25 MG TABLET 60S	PVP	EA	60	2.56	0427	N	SP020003H9104	CAT			DAKO
TOPRAMATE 50 MG TABLET UD 100S	PVP	EA	100	4.34	0434	N	SP020005H9105	CAT			DMSP
TOPRAMATE 25 MG TABLET 500S	PVP	EA	500	25.27	0505	N	SP020003H9101	CAT			AMBE
TOPRAMATE 50 MG TABLET 1000S	PVP	EA	1000	51.00	0510	N	VA797P0233	VNC			CARD
TOPRAMATE 100 MG TABLET UD 100S	PVP	EA	100	5.27	0527	N	SP020005H9105	CAT			DMSP
TOPRAMATE 50 MG TABLET 60S	PVP	EA	60	3.20	0533	N	SP020003H9104	CAT			DAKO
TOPRAMATE 50 MG TABLET 60S	PVP	EA	60	3.40	0567	N	VA797P0233	VNC			CARD
TOPRAMATE 100 MG TABLET UD 100S	PVP	EA	100	5.52	0592	N	SP020005H9105	CAT			DMSP
TOPRAMATE 100 MG TABLET 60S	PVP	EA	60	3.77	0628	N	SP020003H9104	CAT			DAKO
TOPRAMATE 50 MG TABLET 60S	PVP	EA	60	4.10	0683	N	SP020003H9104	CAT			DAKO
TOPRAMATE 200 MG TABLET 60S	PVP	EA	60	5.35	0692	N	SP020003H9104	CAT			DAKO
TOPRAMATE 25 MG TABLET 1000S	PVP	EA	1000	89.20	0892	N	SP020005H9105	CAT			DMSP
TOPRAMATE 100 MG TABLET 60S	PVP	EA	60	5.86	0977	N	SP020003H9104	CAT			DAKO
TOPRAMATE 25 MG TABLET UD 100S	PVP	BC	100	10.87	1087	N	V797P50968	D01			AMBE
TOPRAMATE 25 MG TABLET 60S	PVP	EA	60	6.38	1163	N	SP020003H9103	CAT			CARD
TOPRAMATE 25 MG TABLET 1000S	PVP	EA	1000	120.22	1202	N	SP020003H9103	CAT			CARD
TOPRAMATE 25 MG TABLET 60S	PVP	EA	60	7.58	1265	N	SP020003H9103	CAT			CARD

Records 1 to 24 of 90

Limit: 500

6.1.2-6: Add Item to MTF

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DMISS/CAIM - DAAAD/PHARMACY NMCP - [MTF Catalog - Pharmaceutical - 62756070786]

File Edit Data Navigate Utilities Window Help

Cur Search SOS PC Printer Phys. Inv. Mass. Reg. Stock MTF Bar Code BPE Order Doc/In/Out Issues Receipts Delivery List Reports Trace Mftr... Check Fields

Basic Technical-Pharmaceutical Acceptable Equivalent Cust Cat **Log On**

Item ID: 62756070786

Commodity Class: PHARMACEUTICAL

NSN: NDC: 62756070786

Short Item Description: TOPIRAMATE 25 MG TABLET 60S

Long Item Description: TOPIRAMATE 25 MG TABLET 60S

Manufacturer: SUN PHARMACEUTICAL INDUSTRIES LTD

Manufacturer Cat. No.: National Motor Freight Class: Standardized: ☐ Marked for Deletion: ☐

Local Field 1: URL: MTF Restrictions: Special Requirements: Destruction Methods: Green Product: UNKNOWN Latex Free: UNKNOWN

SOS	Supplier Name	SOS Type	U/P	U/P Qty	U/P Price	Delivery Method	Vendor Item Number	LDG SOS	Pricing Agreement	Deleted
PVP	BERGEN BRUNSWIG	DPV	BT	60	0.01	JIT	62756070786	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NSO	22-MATERIEL MANAGEMENT	LOG	BT	60	0.01		62756070786	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Add

SOS: PVP - BERGEN BRUNSWIG

Vendor Item Type: NDC Vendor Item Number: 62756070786

Pricing Agreement Type: Pricing Agreement Number:

Pricing Agreement Holder:

U/P: BT U/P Quantity: 60 U/P Price: 0.01 Price Expiration Date:

Delivery Method: JUST-IN-TIME Lead Time Days: NAICS: Estimated Monthly Usage: 0 Report PV Usage: ☐ Date Sent: PV Stocked: ☐

ECAT Supplier ID: ECAT Catalog ID:

6.1.2-7: Edit Item Details

Navy Pharmacy SOP: Supply Operations

Print Barcodes

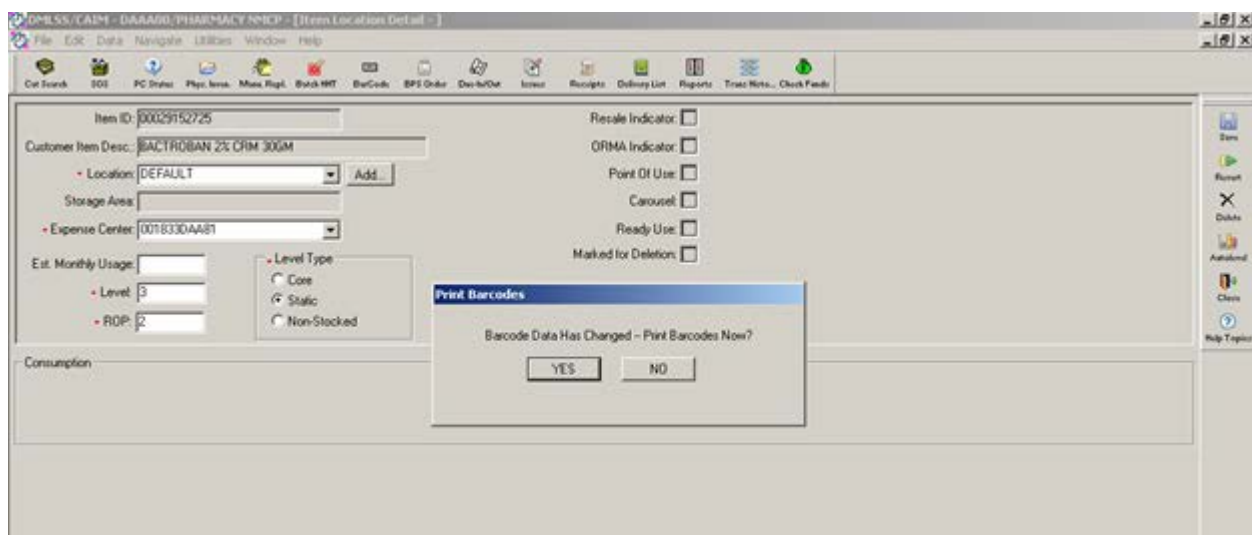
Barcodes should be updated and maintained as part of daily supply operations. Barcodes should be printed and updated on the shelf for the following reasons:

- ✓ Updated Level
- ✓ Updated Location
- ✓ New Item

When the Level or item location is updated within the DMLSS catalog, the user will be prompted to print a barcode. The user should print the new barcode and replace the old barcode. If the user is printing a barcode for a new or substituted item, they must ensure that they non-stock or delete the old item once a new barcode is printed and placed on the shelf. For information on how to non-stock or delete items from the DMLSS catalog, refer to [Non-Stock or Delete Items](#).

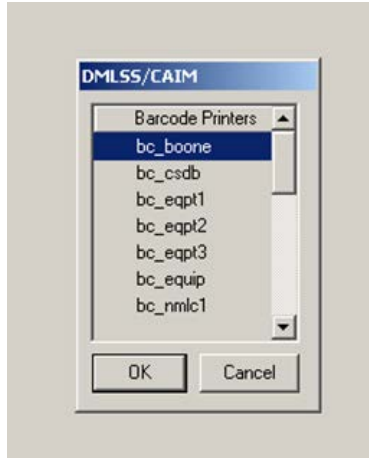
The steps for printing a barcode are (see Figures 6.1.2-8 and 6.1.2-9):

- ✓ Follow appropriate steps to update an item's Level or location, or to add a new item to your DMLSS catalog
- ✓ Click **Save**
- ✓ A pop-up message will prompt you to print a barcode. Click **Yes** (see Figure 6.1.2-8)
- ✓ Another pop-up message will prompt you to select the correct barcode printer location. Select the correct location and click **OK** (see Figure 6.1.2-9)



6.1.2-8: Barcode Print Screen

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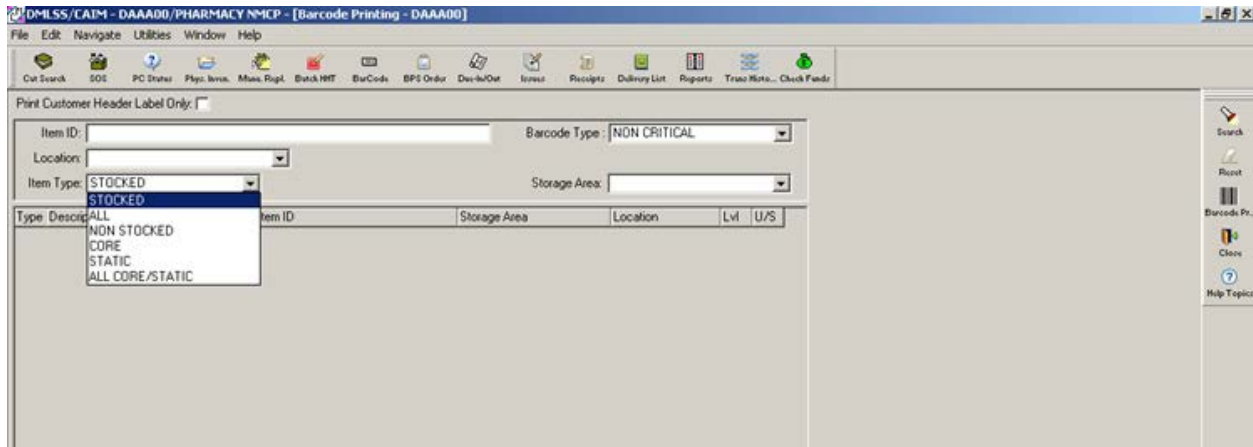
6.1.2-9: Barcode Printer Location Selection

The steps for mass printing barcodes are (see Figures 6.1.2-10 and 6.1.2-11):

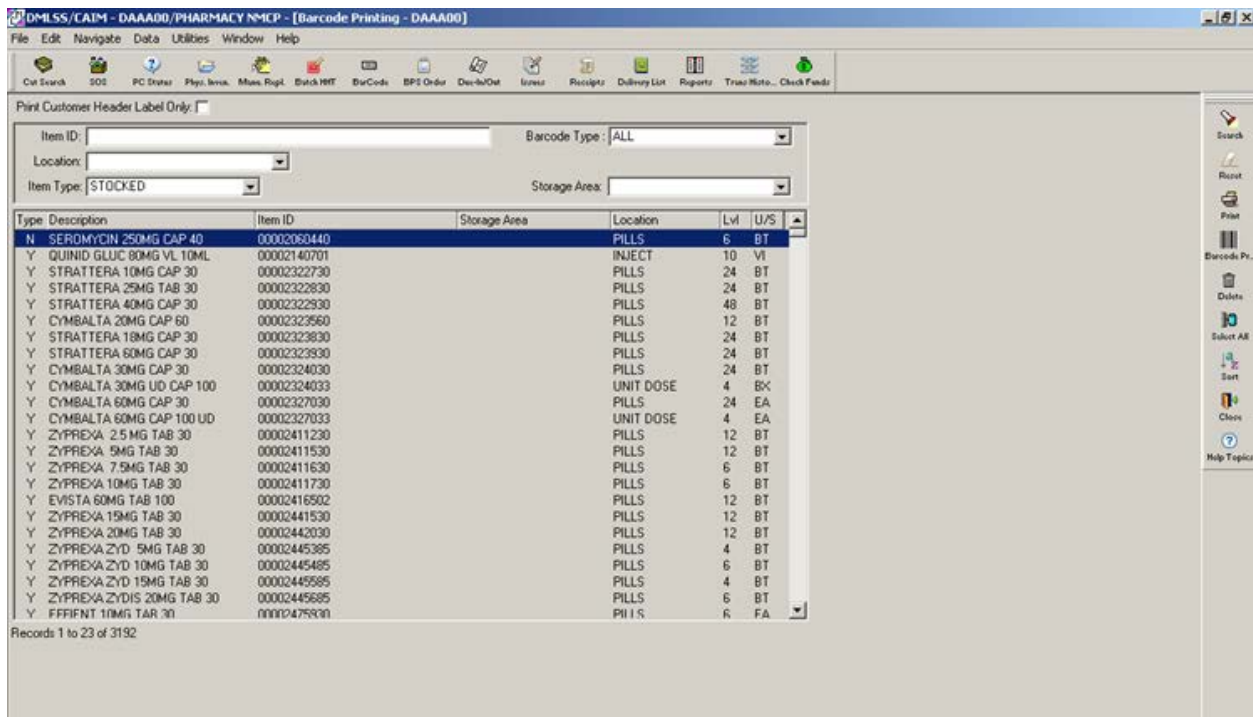
- ✓ Select the **Customer Area Inventory Management (CAIM)** module
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Click **Barcode** on horizontal toolbar (see Figure 6.1.2-10)
- ✓ The user can search items based on several criteria:
 - **Item ID:** A specific Catalog record.
 - **Barcode Type:** Types of barcode labels.
 - **Location:** Area/location in pharmacy where items are stored.
 - **Item Type:** Established Level types of items.
- ✓ Click **Search** on the vertical toolbar after specifying the search criteria.
 - In the screenshot example provided in *6.1.2-10: Barcode Search*, the complete catalog was searched for only stocked items.
- ✓ Select items that require printed barcode labels (see Figure 6.1.2-11)
 - Note: A maximum of 100 barcodes can be selected to print at one time. Use Shift or Ctrl keys to highlight multiple records.
 - When printing a single barcode or if a customer header label is ONLY needed, check '**Print Customer Header Label Only.**'

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- ✓ Click **Barcode Print** on the vertical toolbar.
- ✓ A pop-up message will prompt you to select the correct barcode printer location. Select the correct location and click **OK**.



6.1.2-10: Barcode Search



6.1.2-11: Barcode Search Results

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6.1.3 Procure and Order Pharmacy Supply

Pharmacy staff shall walk the shelves with a Personal Digital Assistant (PDA) and visually identify items to order. If the PDA is not functional, pharmacy staff may also utilize note taking materials to record low-stock items and place a manual order. If utilizing the PDA, pharmacy staff shall scan the item and enter the shelf count into the PDA, which will update the on-hand inventory quantity. Once a barcode is scanned, DMLSS will identify if there is an order due-in or determine if the count is below the ROP and then order up to the item Level.

The steps for using the PDA to order stocked items (i.e., Level > 0) are:

- ✓ Click on **yellow ON/OFF** button located at the top left of the PDA
- ✓ To begin, tap upper left hand corner of screen (**Windows Start Flag**)
- ✓ Tap on **DMLSS CES**
- ✓ Accept DoD computer system message. Tap to continue
- ✓ Tap **Replenish Inv**
- ✓ Enter **DMLSS Login**
- ✓ Click **Batch**
- ✓ Tap **Yes** to overwrite the file and create a new file called caimdata.dat. Tap **No** if you wish to keep data that has not been downloaded yet due to process interruptions or scanning more than one customer (see Figure 6.1.3-1)
- ✓ Scan the **Customer Header Label**. Ensure Customer Barcode shows Inv. Method of **Shelf Count**. If the old customer barcode is scanned, an error will occur
- ✓ After scanning the barcode label, the **Item Barcode** screen opens. Use it to scan the barcodes of the items that need to be replenished (see Figure 6.1.3-2)
- ✓ Enter the **Shelf Count Quantity** and tap **OK** (see Figure 6.1.3-3)
- ✓ When finished scanning, press **the Cancel button twice** to return to the main menu
- ✓ Place the PDA in the docking station to transmit the file. The **Active Sync (or other PC communication tool)** icon will be displayed on the desktop when the PDA is ready. From the PDA's main menu, tap **Send File (Batch)**
- ✓ Select **OK** (Inventory is the default)
- ✓ The Send File Status message indicates that the Batch File was successfully scheduled to send. **DO NOT PRESS "OK"** on this screen until data has been uploaded to DMLSS (Data will be lost if not secured)

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- ✓ Tap **OK**

If the Batch file has been successfully uploaded to DMLSS, the following steps are necessary for processing the order:

- ✓ In DMLSS, select **Batch HHT**
- ✓ Click **OK** (DMLSS displays the number of valid records)

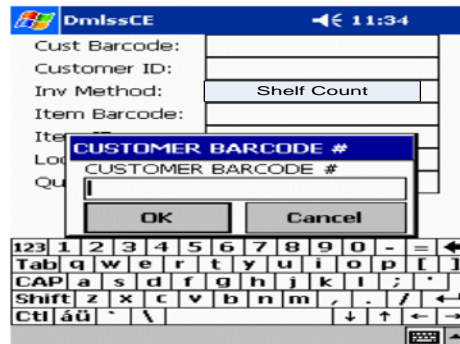


Figure 6.1.3-1: PDA Customer Barcode Screen



Figure 6.1.3-2: PDA Item Barcode Screen

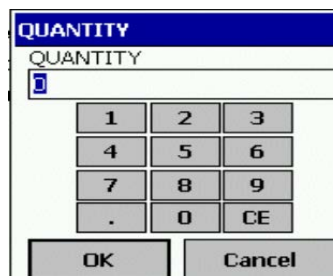


Figure 6.1.3-3: PDA Quantity Screen

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Replenishment exceptions may occur when generating order requirements and are posted to the DMLSS Customer In Box. Exceptions indicate the requirement for the specific item was not generated and an order is NOT pending. Exceptions occur for the following reasons:

- There is an existing due-in for the item, so additional quantity is not required. Not Replenished (RQMTS SATISFIED)
- The Shelf Count is greater than Estimated On-Hand (EOH) quantity
 - If material is placed on the shelf without processing the DMLSS receipt, there is an inventory discrepancy until the receipt is processed
 - An actual inventory discrepancy exists (Inventory quantity is greater than EOH quantity)
- Item has Level = 0. For these non-stocked items, refer to [Process Off-Line Submit Orders](#)
- If the Shelf Count entered is not at or below the ROP, no order will be generated (e.g., Level = 12; ROP = 10; Shelf Count = 11)

Use the following steps to review the replenishment exceptions:

- ✓ Select **the Customer Area Inventory Management (CAIM) module**
- ✓ Select specific **Customer ID** from the Customer screen
- ✓ Highlight **Replenishment Exception** pending action in Customer In Box
- ✓ Click **Jump To** (running man icon)
- ✓ Review Exceptions and determine disposition
 - If not below ROP a due in exists, **highlight line item**, and click **Delete**
 - If there is an additional quantity to order remaining, **highlight line item**, click **Off-line Submit**, and **Input Qty** to be ordered

After building an order, pharmacy staff shall utilize the BPS function to execute the order. The steps for executing the BPS order are:

- ✓ Select the **Customer Area Inventory Management (CAIM) module**
- ✓ Select Pharmacy **Customer ID**
- ✓ Click **BPS Order**
- ✓ Highlight Source of Supply (SOS) Code = Prime Vendor Pharmaceutical (**PVP**)
- ✓ Click **OK**

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- ✓ Highlight **PVP**
 - To review order, click **Detail**. Review item(s) and their respective quantities
 - If adjustments are necessary, highlight item, click **Due Out tab** and adjust quantity
- ✓ Click **Close**
- ✓ Click **Execute**
- ✓ Click **Process**

Status edits are returned once the order has been received by the PV. The steps for reviewing and resolving status edits are below:

- ✓ Select the **Customer Area Inventory Management (CAIM)** module
- ✓ Select Pharmacy **Customer ID**
- ✓ Highlight **Status Edits Report-Customer** pending action in Customer In Box (see Figure 6.1.3-4)
- ✓ Click **Jump To** (running man icon)
- ✓ Enter **Pharmacy Customer ID** (see Figure 6.1.3-5)
- ✓ Click **OK**
- ✓ Click on the third tab labeled **Part 3-Processed** (See Figure 6.1.3-6)
- ✓ Select the **Status** column to sort by type of status edit
- ✓ Items will be sorted by **Status Code**
- ✓ Delete all items with an **Item Accepted (IA)** status code. These items have been accepted by the PV with no edits. See Figure 6.1.3-7 for a list of all status codes and descriptions.
- ✓ Items with a status code beginning with “**R**” have been rejected by the PV. Items can be rejected for a number of reasons, including item shortages and an item no longer being on contract.
- ✓ Select alternatives for rejected items and substitute accordingly for this order.

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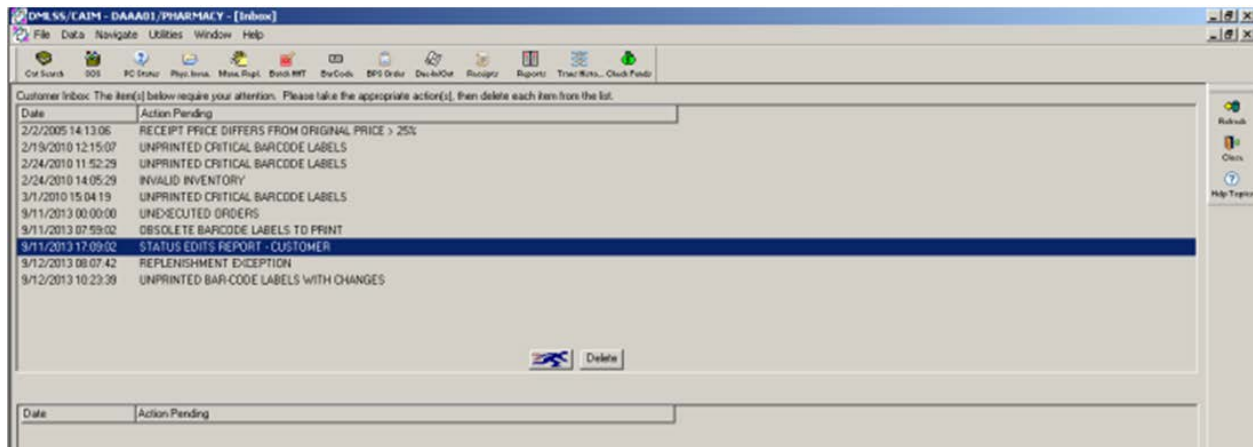


Figure 6.1.3-4: Customer In Box

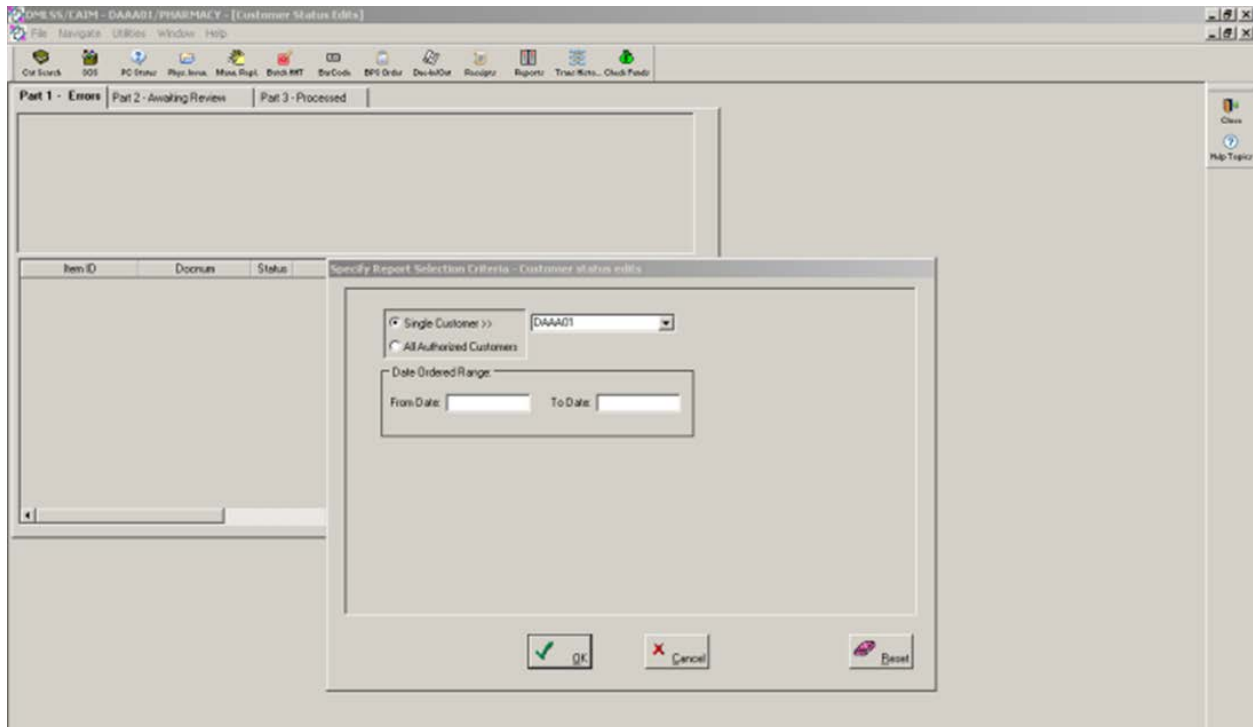


Figure 6.1.3-5: Search

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DMSS/CAIM - DAAA01/PHARMACY - [Customer Status Edits]

Part 1 - Errors | Part 2 - Awaiting Review | **Part 3 - Processed**

STATUS DETAIL

Customer ID: DAAA01 Reason: Item Accepted

Date Posted: 11 Sep 2013

Est. Ship/Release: 11 Sep 2013

Item Desc: 60 DRAM 1-CLIC AMBER VALS CLIN: 4

Contract No: SPHC000503104 Call No: CV45 External Doc:

Item ID	Docnum	Status	Item Description	Reason Description
9670570300	N 3594332544253	IA	60 DRAM 1-CLIC AMBER VALS	Item Accepted
96705701800	N 3594332544252	IA	16 DRAM 1-CLIC AMBER VALS	Item Accepted
96705615500	N 3594332544251	IA	1-CLIC VIAL CAP FOR 30.40/60 DRAM	Item Accepted
96705615400	N 3594332544250	IA	1-CLIC CLOSURES, FITS 16 & 20 DRAM	Item Accepted
96705615500	N 3594332544251	ID	1-CLIC VIAL CAP FOR 30.40/60 DRAM	Shipment Notice/Manifest
96705703000	N 3594332544253	ID	60 DRAM 1-CLIC AMBER VALS	Shipment Notice/Manifest
96705701800	N 3594332544252	ID	16 DRAM 1-CLIC AMBER VALS	Shipment Notice/Manifest
9670615400	N 3594332544250	ID	1-CLIC CLOSURES, FITS 16 & 20 DRAM	Shipment Notice/Manifest

Print List Delete Selected

Figure 6.1.3-6: Sort Status Code

DMSS/System Services - [Centrally Managed Table - STATUS CODE (MILSTRIP)]

Part 1 -

8/26/2013 13:57:07 STATUS CODE (MILSTRIP) Page 4 of 5

Code	Description
FC	Request for improved status
FE	Customer ID Not on File (MEDLOG)
FD	Item is coded as Forward Owned (MEDLOG)
FQ	Insufficient Funds in PFMR (MEDLOG)
IA	Item Accepted
IB	Item Backordered
ID	Shipment Notice/Manifest
IP	Item Accepted, Price Changed
IQ	Item Accepted, Quantity Changed
IR	Item Rejected
IS	Item Accepted, Substitution Made
MC	Material Obligation Validation Confirmed
MP	Material Obligation Validation Reinstatement Request (APRI) Sent
MR	Material Obligation Validation No Longer Required
PF	Price Verification Failed
PV	Price Verified
QD	QUANTITY DECREASE, BACKORDERED ITEM CANCELLATION
R1	Item Rejected, Not a Contract Item
R2	Item Rejected, Invalid Item Product Number
R3	Item Rejected, Invalid Unit of Issue
R4	Item Rejected, Item is on Mfg or Nat'l Backorder
R5	Item Rejected, Reorder Item as a Just In Time (JIT) Order
R6	Item Rejected, Item is not on the Customer's Usage List
R7	Item Rejected, Reorder Item as a Drop Shipment Order
R8	Item Rejected, Reorder Item as a Surge Order
RA	RIA Receipt Acknowledgement
RB	RIB Receipt Acknowledgement Response
RC	Request Cancellation
RF	RIF Follow-up Request for Receipt Acknowledgement
SS	Ship Status
TD	Troubled Due-In
U1	User entered ship date via duem detail window
U2	User entered estimated release date via duem detail window
U3	Receipt or cancellation reversal processed

ROW 1 OF 144

Select the row required

dmssrdb@amednics1a0c42 3.1.2.0.805.808 For Official Use Only

Figure 6.1.3-7: Status Code Glossary

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Process Off-Line Submit Orders

The Off-Line Submit order process serves three key functions:

- Provides the ability to order for items with replenishment exceptions
- Provides the ability to order a quantity greater than the established stock level for special or one time use requirements
- An ordering process for non-stocked items (i.e. Level = 0)

The steps for processing an Off-Line Submit Order are:

- ✓ Select **Navigate** (see Figure 6.1.3-4)
- ✓ Select **Orders**
- ✓ Select **Offline Submit/Non-Submit**
- ✓ Select **Yes** in **Submit** field
- ✓ Select **PVP** in **SOS Cd** field
- ✓ Click **Add Non-Submit icon**
- ✓ Search by **Item ID** or **Item Description**
- ✓ Select item
- ✓ Click **OK**
- ✓ Enter **Order Quantity**
- ✓ For additional line items, click **Add Non-Submit**
- ✓ Search by **Item ID** or **Item Description**
- ✓ Check additional items – more than one selection is permissible (see Figure 6.1.3-5)
- ✓ Click **OK**
- ✓ Enter **Order Quantity**
- ✓ Click **Execute** (see Figure 6.1.3-6)

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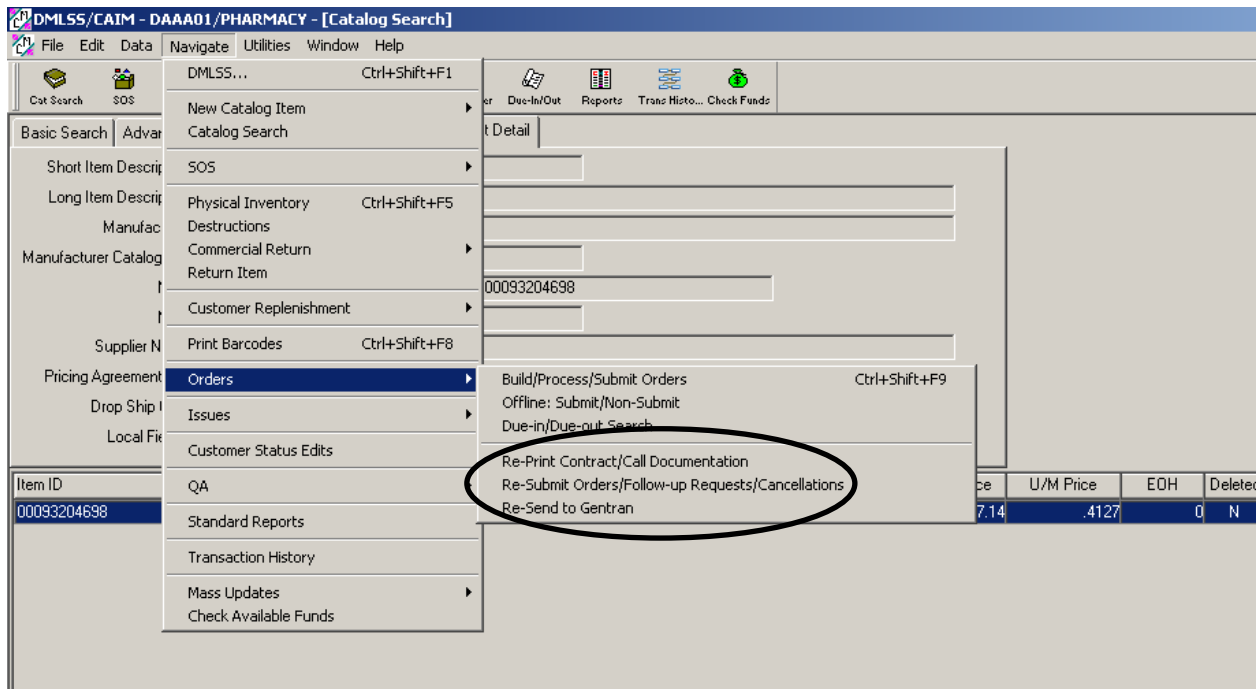


Figure 6.1.3-4: Off-Line Submit/Non-Submit Navigation

Navy Pharmacy SOP: Supply Operations

Non Submit ☐ **Option** ☒ **SOS** ☐ **ITEM** Item ID:

Submission ☒ **SOS Cd:** PVP **Supplier:** CARDINAL

Contract ☐ **PV Credit:** **PV Credit Amount:**

Method: FILE TRANSFER PROTOCOL (F*) **Form:** ANSI X.12 850 TXN SET

Call Num: **Number:** SPM2DX1000035 **Type Cd:** D01

Select ITEM ID

Search By: ☐ Item ID ☒ Item Description

Select	Item Description	Item ID
<input checked="" type="checkbox"/>	CALCITRIOL .25MCG 100	00054000725
<input type="checkbox"/>	FLECAINIDE ACETATE 100 MG TAB 100S	00054001125
<input type="checkbox"/>	PREDNISONE 20 MG TABLET 500	00054001829
<input type="checkbox"/>	MEFLOQUINE 250MG 25S	00054002511
<input type="checkbox"/>	IPRATROPIUM NASAL 30ML 1S	00054004544
<input type="checkbox"/>	CITALOPRAM 10 MG/5 ML SOLUTION 240ML	00054006258
<input checked="" type="checkbox"/>	ROPINIROLE HCL 1 MG TABLET 100S	00054011825
<input type="checkbox"/>	LITHIUM CARBONATE 150 MG CAP	00054252625
<input type="checkbox"/>	LITHIUM CARBONATE 300 MG CAP	00054252731
<input type="checkbox"/>	DEXAMETHASONE 0.5 MG/5 ML LIQ 240ML	00054317757
<input type="checkbox"/>	FUROSEMIDE 10 MG/ML SOLUTION 120ML	00054329450
<input checked="" type="checkbox"/>	PROPRANOLOL 20 MG/5 ML SOLN	00054372763
<input type="checkbox"/>	DEXAMETHASONE 4MG 100S	00054418425
<input type="checkbox"/>	PROPANTHELINE 15MG100S	00054472125
<input type="checkbox"/>	RETIN-A 0.025% CREAM	00062016501
<input type="checkbox"/>	RETIN-A 0.05% CR 20GM	00062017512

Figure 6.1.3-5: Off-Line Submit Ordering Process

Non Submit ☐ **Option** ☒ **SOS** ☐ **ITEM** Item ID:

Submission ☒ **SOS Cd:** PVP **Supplier:** CARDINAL

Method: FILE TRANSFER PROTOCOL (F*) **Form:** ANSI X.12 850 TXN SET

Call Num: **Number:** SPM2DX1000035 **Type Cd:** D01

Order Details Table:

Item ID	Location	Expense Center	Link	U/P	Order Quantity	Price	Ext. Price	Advice Cd	Project Cd	Priority	Demand Cd	Req Deliv Dt	Vendor Item Number	Document Number	Docum Date	Clk CD	Level	EC
00904174840	PILLS 1	660963DAA81	<input checked="" type="checkbox"/>	BT		\$15.54		2D		12	Recurring		00904174840 - NDC (I)		04/25/2013		8	

Figure 6.1.3-6: Off-Line Submit Order Execution

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Process Off-Line Non-Submit Orders

Off-Line Non-Submit is used for any manual order placed to the PV. PVP Credit Orders and Schedule-II orders are processed in DMLSS using the Off-Line non-submit function. Non-Submit orders require pharmacy staff to submit a DD 1155 to the PV.

The steps for processing an Off-Line Non-Submit Order are:

- ✓ Select **Navigate** (see Figure 6.1.3-4)
- ✓ Select **Orders**
- ✓ Select **Offline Submit/Non-Submit**
- ✓ Select **No** in **Submit** field (see Figure 6.1.3-7)
- ✓ Select **PVP** in **SOS Cd** field
- ✓ Click **Add Non-Submit**
- ✓ Search by **Item ID** or **Item Description**
- ✓ Select item (see Figure 6.1.3-8)
- ✓ Click **OK**
- ✓ Enter **Order Quantity**
- ✓ For additional line items, click **Add Non-Submit**
- ✓ Search by **Item ID** or **Item Description**
- ✓ Check additional items - more than one selection is permissible (Note: Once a Schedule-II medication is selected the list will be restricted to only Schedule-II DMLSS Catalog Items)
- ✓ Click **OK**
- ✓ Enter **Order Quantity** (see Figure 6.1.3-9)
- ✓ Click **Execute**

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The screenshot shows the 'Non Submit' form in the DMLSS/CAIM system. The form includes fields for 'Option' (SOS or ITEM), 'Item ID', 'SOS Cd' (PVP), 'Supplier' (CARDINAL), 'Submission Method' (FILE TRANSFER PROTOCOL), 'Form' (ANSI X12 850 TXN SET), 'PV Credit', 'PV Credit Amount', 'Contract Call Num' (AUTO), 'Number' (SPM2DX10D0035), and 'Type Cd' (B64). A table at the bottom displays order details:

Item ID	Location	Expense Center	Link	U/P	Order Quantity	Price	Ext. Price	Advice Cd	Project Cd	Priority	Demand Cd	Req Deliv Dt	Vendor Item Number	Document Number	Docum Date	Cl CD	Level	ET
00003029305	INJ 1	660963DAA81	<input checked="" type="checkbox"/>	VI		\$7.90		2D		12	Recurring		00003029305 - NDC (I		04/25/2013		20	

Figure 6.1.3-7: Offline Non-Submit Order

The screenshot shows the 'Non Submit' form with a 'Select ITEM ID' dialog box open. The dialog box has a 'Search By' section with 'Item ID' and 'Item Description' options. The 'Item Desc' field contains 'IBUPRO'. A list of items is displayed:

Item Description	Item ID
IBUPROFEN 400MG 500S	00904174840
CALCIUM 500MG/1000	00904188380
ACETAMINOPHEN 325MG UD 100S	00904198261
ACETAMINOPHEN 160/5ML 1S	00904198500
SEPTRA 800-160 MG	00904272540
CARBAMIDE PEROX 6.5% 15ML 1S	00904322035
DEEP SEA SALINE NASAL 45ML	00904386575
ASPIRIN 81MG CHEW 1X36S	00904404073
CYANOCOBALAMIN 250MCG TAB 1X130	00904421813
PSEUDOPHED 30MG 24S	00904505324
PSEUDOPHED 30MG 100S	00904505359
IBUPROFEN 600MG 800S	00904518640
IBUPROFEN 800MG 500S	00904518740
TYLENOL 80 MG TABLET CHEW 30S	00904525646
PRENATAL TABLET 100S (NEW)	00904531360
CALCIUM & VIT D 500/200MG 1000	00904546080

The dialog box also includes 'OK' and 'Cancel' buttons.

Figure 6.1.3-8: Add Non-Submit Line Item

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DMSS/CAIM - DAAA01/PHARMACY - [Offline Orders]

File Edit Data Navigate Utilities Window Help

☒ SOS ☐ ITEM Item ID:
 • SOS Cd: PVP Supplier: CARDINAL
 Submission Method: FILE TRANSFER PROTOCOL (F) Form: ANSI X.12 850 TXN SET
 PV Credit PV Credit Amount:
 Contract Call Num: AUTO Number: SPM2DX1000035 Type Cd: D01

☐ Use Purchase Card Status: Source Does Not Allow Purchase Cards

Item ID	Location	Expense Center	Link	U/P	Order Quantity	Price	Ext. Price	Advice Cd	Project Cd	Priority	Demand Cd	Req Deliv Dt	Vendor Item Number	Document Number	Docum Date	Cl CD	Level	EC
00904174840	PILLS 1	660963DAA81	<input checked="" type="checkbox"/>	BT	4	\$18.52		2D		12	Recurring		00904174840 - NDC (I)		04/25/2013		8	

Execute Refresh Sort Close Help Topics

Figure 6.1.3-9: Offline Non-Submit Order Quantity

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6.1.4 Receipt Pharmacy Supply Order

Separation of Functions

Note: Pharmacy staff shall ensure they are in compliance with separation of functions as referenced in [Navy Marine Corps Acquisition Regulation Supplement \(NMCARS\) 5203.101-1](#).

DoN contracting activities, purchasing offices, and contract administration offices are responsible for ensuring that a single individual performs only one of the following functions:

- I. Initiation of the requirement.
- II. Award of the contract or placement of the order.
- III. Receipt, inspection, and acceptance of supplies and services.

If circumstances preclude an individual from performing a single function, as a minimum, the individual responsible for the award of the contract or placement of an order should not perform the receipt, inspection, and acceptance function.

- The majority of Navy Pharmacy sites use Shelf Count Logic to order their stocked and non-stocked pharmaceuticals. As a result, separation of functions is achieved by the following process:
 - ✓ Initiation of the Requirement.
 - DoD and local P&T Committee processes determine items to be stocked.
 - Stocked items have established stocking levels approved by the Pharmacy Department Head.
 - ✓ When pharmacy supply staff conducts their replenishment inventory, the requirement is determined by the pre-approved stocking levels.
 - ✓ The individual building the order is conducting a physical inventory and is not considered the initiator of the requirement. As a result, this individual can execute (or place) the order.
 - ✓ Separation of functions must still occur between the person executing/placing the order and the person receipting the order.
- Special order requests or requests to fill non-stocked items are initiated through the local P&T Committee or the Pharmacy Department Head to maintain consistency with the process followed for initiating a requirement. Pharmacy supply staff must still ensure that a separation of duties exists between executing and receipting the item.
- Navy Pharmacy sites that do not currently use Shelf Count Logic tend to be extremely small clinics, but they are still governed by local P&T committee processes. As a result,

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pharmacy staff must ensure that, at a minimum, the individual responsible for the placement of the order should not perform the receipt, inspection, and acceptance function.

Pharmacy staff shall unpack the orders and ensure that each line item is not set to expire for at least six months. Additionally, all packaging should be intact and should show no sign of damage or wear. All quantities and manufacturer names must be verified to the paper PV invoice.

Proper receipt and acceptance of goods is needed to verify that items and quantities delivered to the Activity are the same as the items and quantities ordered, that the goods have been physically received, and that disbursements can be traced and matched to item invoices. To implement proper separation of function, the individual receiving, inspecting, and accepting the goods in DMLSS must not be the same individual placing the order. Orders must be receipted in DMLSS by a member of the pharmacy staff before a new order can be built.

Pharmacy staff shall only receipt the actual quantity of medication received using the following steps:

- ✓ If the quantities match, **circle** the quantity on the packing list or bill of lading
- ✓ If the quantities do not match, **cross out** the listed quantity, **write** and **circle** the actual quantity received in the shipment and contact the PV to troubleshoot the error.
- ✓ **Sign** and **date** the processed packing list or bill of lading to confirm that this verification was completed. The signature must be traceable and accountable.

Pharmacy staff shall maintain the packing list or bill of lading with the item until the acceptance procedures are completed. Once complete, the signed, circled and dated packing list or bill of lading shall be retained in the supporting documentation file. Pursuant to the 05 October 2011 SECNAV Memorandum and 02 December 2011 BUMED Memorandum titled "[Immediate Retention of All Documentation to Support Current and Future Department of the Navy Financial Audits](#)," effective immediately and until further notice, retain all documentation in support of a financial statement audit indefinitely.

The steps for receipting, validating, and stowing materials in DMLSS are:

- Click **Navigate**
- Click **Receipts**
- Enter search criteria (i.e. PO #, item ID, Document #)
- Once item(s) is located, validate receipt quantity
- Process box is auto-checked (See Figure 6.1.4-1)
 - If electronic vendor status not received, box will be unchecked

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- If QA message on item, box will be unchecked
- Check process box to process receipt
- Click **Process Receipts** when completed
- Click **Yes** when the following **Receipt and Acceptance** message appears as a pop-up screen (See Figure 6.1.4-2):
 - *DMLSS/CAIM-[Receipt and Acceptance]* Are you acknowledging receipt and acceptance for the item(s) selected? Note: if you select 'No', receipt(s) will NOT be processed.
- Click **DD 1155** on right toolbar to print a copy of the receipt.
 - Note: Printing a DD 1155 is optional for routine orders. A DD 1155 is only required for Offline Non-Submit (PVP Credit and Schedule-II) Orders
- Select **Process** to print summary of receipts
- Click **Cancel** at barcode screen
- Select **Yes** or **No** to print backorder release list report
- Select **Yes** or **No** to print the Material Inspection and Receiving Report (Form DD 250)
- Place receipted materials on shelves
- Rotate oldest materials on shelves to front and the newest to back

DMLSS/CAIM - DAAA01/PHARMACY - [Receipt Search]

File Edit Data Navigate Utilities Window Help

Ctrl Search SOS BarCode Due-In/Out Issues Receipts Delivery List Reports Trans Hist... Check Funds

Scope: ☐ MTF ☒ Customer Cust. ID: DAAA01 Search ☒ Active ☐ In-Active Limit: 500

Search Delivery List Search PPD Shipments Search Summary Result

Item ID: 00603421421
Document No: N6609630804217 Date: 21 Mar 2013
Cust Item Desc: LISINOPRIL 40 MG TABLET 500S
Contract No: SPM2DX10D0035 Call No: 8016
Local Contract No: SOS: PVP
Customer ID: DAAA01 DuIn Quantity: 4
Status U/P Price: 22.17 Total Cancelled: 4
U/P: EA Total Discrepant: 0

Receipts by Call Number Summary

Summary of items being receipted against each call

Call Number	Sos Cd	Total # of Line Items	Total Amount
8016	PVP	4	\$302.42

Process Cancel

Item Id	Document No	Re
00603421032	N6609630804214	
00603421132	N6609630804215	
00603421232	N6609630804216	
00603421421	N6609630804217	

ODC Code	QA	Discrep
1 - Government Source		
1 - Government Source		
1 - Government Source		
1 - Government Source		

Search Clear Reset Print Detail Proc Rpts Discrepancy Barcodes DD1155 Unlock Delete Disc... Return Assh... Close Help Topics

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Figure 6.1.4-1: Order Receipt in DMLSS

DMLSS/CAIM - DAAA01/PHARMACY - [Receipt Search]

File Edit Data Navigate Utilities Window Help

Cat Search SOS BarCode Debit/Out Issues Receipts Delivery List Reports Trans Hist... Check Fields

Scope: ☐ MTF ☒ Customer Cust. ID: DAAA01 Search ☒ Active ☐ In-Active Limit: 500

Search Delivery List Search RFID Shipments Search Summary Result

Item ID: 00603421421
 Document No: N6609630804217 Date: 21 Mar 2013
 Cust Item Desc: LISINOPRIL 40 MG TABLET 500S
 Contract No: SPM2DX10D0035 Call No: B016
 Local Contract No: SQS: PVP
 Customer ID: DAAA01 Dueln Quantity: 4
 Status U/P Price: 22.17 Total Cancelled: 4
 U/P: EA Total Discrepancy: 0

Item Id	Document No	Receipt Qty	Cancel Qty	Status Price	Process	Local Contract	ODC Code	QA	Discrepancy
00603421032	N6609630804214	1	0	15.00	✓		1 - Government Source		
00603421132	N6609630804215	2	0	22.13	✓		1 - Government Source		
00603421232	N6609630804216	DMLSS/CAIM - [Receipt and Acceptance]							
00603421421	N6609630804217	1 - Government Source							

Are you acknowledging receipt and acceptance for the item(s) selected?
 Note: if you select 'No', receipt(s) will NOT be processed.

Yes No

Figure 6.1.4-2: Receipt and Acceptance in DMLSS

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6.1.5 Manage DMLSS Catalog

Catalog maintenance is a key component of effective inventory management of pharmaceuticals. Pharmacy staff shall conduct catalog maintenance routinely to ensure that the correct items, with appropriate Levels that meet patient and mission need, are stocked within the pharmacy.

Items that are no longer required for use and do not need to be stocked within the pharmacy (e.g., items discontinued by a manufacturer) should be non-stocked or deleted from the Pharmacy's DMLSS catalog. Deleting an item or assigning an item to non-stocked status automatically changes the Level and ROP to 0. This process facilitates effective catalog maintenance and provides greater oversight into the items that are actually stocked within the pharmacy. For additional information on setting and updating your Levels and ROPs, refer to [6.1.2 Establish and/or Modify Stocking Levels](#).

The Business Objects (BO) function in DMLSS allows pharmacy staff to run custom reports that aid in managing the DMLSS catalog. Pharmacy staff shall use the customizable reports as a leadership tool to establish appropriate Days of Stock and evaluate pharmacy expenditures.

The steps for opening and viewing DMLSS Business Objects Reports are:

- ✓ Save **Business Object Report Template to a file location** (i.e. Desktop). DMLSS must be open to view BO reports
- ✓ Log into **DMLSS**
- ✓ Select **Business Objects**
- ✓ Select **Materiel Management**
 - Click **Launch BO**
 - Open **file location where Business Objects Report Template** is saved
 - **Highlight report and click open**. This report will provide data items related to inventory values and levels in the pharmacy
 - Click **Refresh**. This will allow the user to view current data for a specific pharmacy customer
 - Enter **Pharmacy Customer ID** (See Figure 6.5.1-1)
 - Click **OK**

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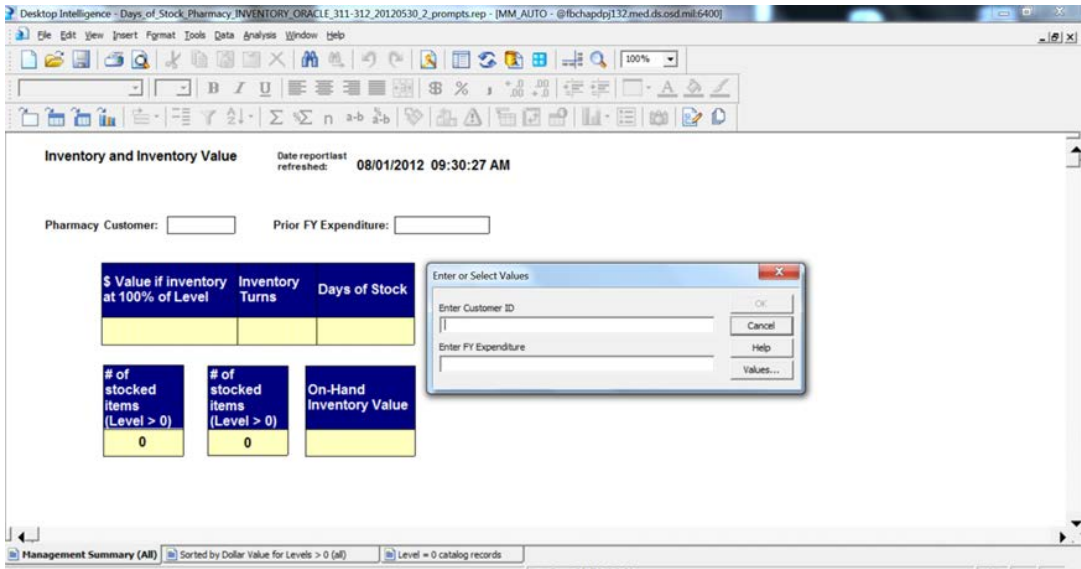


Figure 6.1.5-1: Pharmacy Inventory Report Business Objects

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6.2 Manage PVP Returns and Credits

Each pharmacy has an account for PV credits. All credits must be spent within 120 days.

6.2.1 Manage Pharmaceutical Returns

6.2.2 Update PVP Credit Account

6.2.3 Execute PVP Credit Order

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6.2.1 Manage Pharmaceutical Returns

Pharmacy staff shall seek to minimize the potential for the dispensing of expired drugs through effective inventory management, identification of expired drugs, and removal of expired drugs.

At least one time per month, pharmacy staff shall review pharmaceutical inventory and conduct the following steps:

- ✓ Remove from inventory pharmaceuticals that will expire within 30 days
- ✓ Isolate and securely store the expired pharmaceuticals away from in-date pharmaceuticals

Pharmacy staff shall clearly mark the container for expired pharmaceuticals and coordinate reverse distribution with an identified vendor.

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6.2.2 Update PVP Credit Account

Pharmacy staff shall establish a new credit account in DMLSS or update the DMLSS credit account balance to match the vendor's current report.

The steps to establish or update a PVP credit account are (see Figure 6.2.1-1):

- ✓ Verify the accuracy of credits with the PV
- ✓ Log into DMLSS and launch the **Customer Area Inventory Management (CAIM) Module**
- ✓ Select **Customer ID** from the Customer screen
- ✓ Select **Navigate, Commercial Return**, and click **Manage PV Credits**
- ✓ In the Manage PV Credit window, select the **Source of Supply (PVP)** from the SOS dropdown list
- ✓ **Modify Credit** by entering the increased amount in the add credit field
- ✓ Type the reason for the credit increase (e.g., credit memo)
- ✓ Click **Save**
- ✓ Click **OK** in response to the confirmation message

DMLSS/CAIM - DAA000/PHARMACY 21 AMC - [Manage PV Credit]

File Edit Navigate Utilities Window Help

Car Search SOS PC Status Phys. Inven. Mater. Rptg. Batch HHT BarCode BPS Order Dev-In/Out Issues Receipts Delivery List Reports Trace History Check Fields

SOS: PVP Customer: DAA000

Total Credit Amount: 0

Add Credit: 10540.00 Lose Credit:

Reason: ESTABLISH NEW CREDIT ACCOUNT BALANCE

Credit Account Number: 4567-09BC

Save Revert History Goto Web Close Help Topics

Figure 6.2.1-1: Establishing/Updating PVP Credit Account

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6.2.3 Execute PVP Credit Order

A PVP Credit Order is placed with the PV using credit account dollars. The account must have enough credit to pay the full order amount at the time of order execution. Additionally, a DD 1155 must be submitted to the PV to indicate that a credit order was executed.

Credit orders are not processed electronically to the vendor and must be generated in DMLSS as Off-line Non-submit.

The steps to execute and finalize a PVP credit order are:

- ✓ Select **Navigate** (see Figure 6.1.3-4)
- ✓ Select **Orders**
- ✓ Select **Offline Submit/Non-Submit**
- ✓ Select **No** in **Submit** field (see Figure 6.1.3-7)
- ✓ Select **PVP** in **SOS Cd** field
- ✓ Select **PV Credit** (see Figure 6.2.2-1) – Ensure credit amount is greater than or equal to order value
- ✓ Search by **Item ID** or **Item Description**
- ✓ Select item (see Figure 6.1.3-8)
- ✓ Click **OK**
- ✓ Enter next credit **Call Num** (Note: The next Call Num should be pulled from reserved back end PVP Call Numbers)
- ✓ Enter **Order Quantity**
- ✓ For additional line items, click **Add Non-Submit**
- ✓ Search by **Item ID** or **Item Description**
- ✓ Check additional items
- ✓ Click **OK**
- ✓ Enter **Order Quantity** (see Figure 6.1.3-9)
- ✓ Click **Execute**
- ✓ Select **Yes** when prompted to save current order item

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- ✓ Respond appropriately when prompted if there are additional items to add to the present call number
- ✓ Select **Yes** to print DD 1155
- ✓ Click **OK** to confirm successfully submitted order

The screenshot displays the 'DMSS/CAIM - YMEPHA/PHARMACY - [Offline Orders]' application window. The interface includes a menu bar (File, Edit, Data, Navigate, Utilities, Window, Help) and a toolbar with various icons. The main form area contains several sections:

- Submit:** Radio buttons for 'Yes' and 'No'. The 'No' option is selected.
- Option:** Radio buttons for 'SOS' and 'ITEM'. The 'ITEM' option is selected.
- SOS Cd:** A dropdown menu showing 'PVP'.
- Supplier:** A text field containing 'AMERISOURCE BERGEN DRUG COMPANY'.
- Submission:** A section with a 'Method' dropdown set to 'PRINT' and a 'Form' dropdown set to 'DD FORM 1155'.
- PV Credit:** A checked checkbox and a text field for 'PV Credit Amount' showing '190323.69'.
- Contract:** A section with 'Call Num' and 'Number' fields. The 'Number' field contains 'SPM2000501029' and the 'Type Cd' is 'BG4'.
- Table:** A table with columns: Item ID, Location, Expense Center, Link, U/P, Order Quantity, Price, Est. Price, Advice Cd, Project Cd, Priority, Demand Cd, Req Deliv Dt, Vendor Item Number, Document Number, Docum Date, Ctl CD, Level, EOH. The first row contains data: Item ID 00002411230, Location CAPSULE, Expense Center YMEPHA, Link BT, Order Quantity 1, Price \$143.52, Est. Price 20, Advice Cd 13, Project Cd Recurring, Demand Cd 00002411230 - NDC, Req Deliv Dt 08/01/2012, Vendor Item Number 0, Document Number 0, Docum Date 0, Ctl CD 0, Level 0, EOH 0.
- Footer:** Buttons for 'Add Non-Submit', 'Delete Non-Submit', and 'Total Lines'. The 'Total Lines' is 1, and the 'Order Total' is \$0.00.

Figure 6.2.2-1: Offline Non-Submit PV Credit Order

The steps for modifying an existing credit order are:

- ✓ Select **Due-In/Out**
- ✓ Enter the call number for the specific **Credit Order**
- ✓ Click **Search**
- ✓ Highlight the specific line item to be modified/updated
- ✓ Click **Detail**
- ✓ Update the **Status/Price** field with new information (see Figure 6.2.1-2)
- ✓ Click **Save**
- ✓ Click **Close**

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Pharmacy staff can access the PVP Credit Account History using the following steps (see Figure 6.2.2-2):

- ✓ Navigate to **Commercial Return** and click **PVP Credit History**
- ✓ Select **PVP** from dropdown menu
- ✓ Enter **Criteria** and click **Search**

The screenshot shows a software window titled "DMLSS/CAIM - YMEPHA/PHARMACY - [PV Credit History]". The window has a menu bar (File, Edit, Data, Navigate, Utilities, Window, Help) and a toolbar with various icons. Below the toolbar, there are search filters: Scope (IM, AM, CAIM, ALL), SOS (PVP), Org ID (YMEPHA), User, Account Num, Call Num, Start Date, and End Date. The main area displays a table of transactions with columns: Org ID, Acct Number, Call Number, Gain/Loss Amt, Description, Trans Date, User, and Type. The table contains 25 rows of transaction data.

Org ID	Acct Number	Call Number	Gain/Loss Amt	Description	Trans Date	User	Type
YMEPHA	041-082479		5,883.80	INITIAL ACCOUNT SET UP	04/20/2009	WILLIAMH	CAIM
YMEPHA	041-082479		94,080.74	UPDATING CREDIT ACCOUNT	08/04/2009	TYLERTD	CAIM
YMEPHA	041-082479		133,665.00	UPDATED CREDITS	09/18/2009	INVMANGR	CAIM
YMEPHA	041-082479		-120,275.70	UPDATE CREDITS	10/13/2009	INVMANGR	CAIM
YMEPHA	041-082479			CHANGE ACCOUNT NUMBER TO REFLECT PHARMACY'S CREDIT ACCOUNT	10/21/2009	GMELANCO	CAIM
YMEPHA	041-082479		7,321.56	UPDATED CREDITS FOR NOV 09	11/18/2009	INVMANGR	CAIM
YMEPHA	041-082479	AW23	-95,369.14	OFFLINE SUBMIT ORDER PROCESSED	11/20/2009	WALTHALL	CAIM
YMEPHA	041-082479		66,121.26	UPDATED CREDITS FOR DEC 09	12/08/2009	INVMANGR	CAIM
YMEPHA	041-082479		-1,715.27	UPDATED CREDITS FOR JANUARY 2010	01/11/2010	INVMANGR	CAIM
YMEPHA	041-082479		-8,322.25	UPDATED CREDITS FOR FEBRUARY 2010	02/16/2010	INVMANGR	CAIM
YMEPHA	041-082479		10,509.37	UPDATED CREDITS FOR MARCH 2010	03/03/2010	INVMANGR	CAIM
YMEPHA	041-082479		42,205.77	UPDATED FOR APRIL 2010	05/07/2010	INVMANGR	CAIM
YMEPHA	041-082479		28,446.84	UPDATED FOR MAY 2010	05/07/2010	INVMANGR	CAIM
YMEPHA	041-082479	AW26	-46,526.76	OFFLINE SUBMIT ORDER PROCESSED	05/26/2010	WALTHALL	CAIM
YMEPHA	041-082479	AW26	66.00	CAIM RECEIPT PRICE CHANGE	05/28/2010	WALTHALL	CAIM
YMEPHA	041-082479	AW26	315.36	CAIM RECEIPT PRICE CHANGE	05/28/2010	WALTHALL	CAIM
YMEPHA	041-082479	AW26	155.64	CAIM RECEIPT PRICE CHANGE	05/28/2010	WALTHALL	CAIM
YMEPHA	041-082479	AW26	80.16	CAIM RECEIPT PRICE CHANGE	05/28/2010	WALTHALL	CAIM
YMEPHA	041-082479	AW26	118.26	CAIM RECEIPT PRICE CHANGE	05/28/2010	WALTHALL	CAIM
YMEPHA	041-082479	AW26	132.00	CAIM RECEIPT PRICE CHANGE	05/28/2010	WALTHALL	CAIM
YMEPHA	041-082479		-17,089.37	UPDATED FOR JUNE 2010	06/08/2010	INVMANGR	CAIM
YMEPHA	041-082479		3,440.88	UPDATED FOR THE MONTH OF JULY	06/24/2010	CRAMERL	CAIM
YMEPHA	041-082479		12,849.61	UPDATE FOR AUGUST 2010	08/17/2010	INVMANGR	CAIM
YMEPHA	041-082479		-32,270.37	UPDATE CREDIT FOR SEPTEMBER	09/08/2010	INVMANGR	CAIM
YMEPHA	041-082479		-22,743.97	UPDATE CREDIT FOR OCTOBER	10/05/2010	INVMANGR	CAIM
YMEPHA	041-082479		31,271.48	UPDATED CREDITS FOR NOVEMBER 2010	11/12/2010	INVMANGR	CAIM

Figure 6.2.2-2: PV Credit Account Transaction History

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6.3 Manage MMQC Drug Recalls

The Pharmacy Department has the responsibility to provide medications of the highest quality and to remove medications whose quality or labeling is questionable.

Drug recalls are classified by the Food and Drug Administration (FDA) as [Class I, Class II, or Class III](#), depending on the severity of the consequence of exposure to the recalled product. A list of all drug recalls can be found in the [FDA Enforcement Report](#).

Drug recalls conducted at the request of the manufacturer, the FDA, the Defense Logistics Agency – Troop Support (DLA-TS) or the DoD will be adhered to by pharmacy staff. The Pharmacy Department Head is responsible for implementing drug recall procedures immediately upon receipt of a recall notice. The Pharmacy Department Head will direct supply personnel to perform appropriate actions, including sending copies of the recall to all requisite Command clinics and instructing those clinics to perform the recall procedures.

MMQC Drug Recall Management ensures all drug recalls are correctly acknowledged, documented and managed using the Inventory and CAIM modules of the DMLSS application. All recall messages are electronically received in DMLSS during the daily End of Period process.

6.3.1 [Review Inventory Management Drug Recalls](#)

6.3.2 [Review Inventory Management QA – Alert Item Qty On-Hand](#)

6.3.3 [Review Inventory Management QA – Alert Missing or No Item ID Match](#)

6.3.4 [Review Inventory Management QA – New Records](#)

6.3.5 [Review CAIM DMLSS QA Alert Item Quantity Required Customer](#)

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6.3.1 Review Inventory Management Drug Recalls

The QA Record Database records and tracks all actions associated with a Drug Recall/Quality Notice. All customer and materiel management information is captured and centrally maintained in the QA Record. When a drug recall is electronically routed for a specific NDC, the IM module allows pharmacy staff to view the on-hand quantities.

The steps to conduct a QA Records Search are:

- ✓ Go to **IM** module
- ✓ Select **Navigate, QA** and click **QA Search**
- ✓ Enter the **Item ID** or **National Drug Code** of the item (see Figure 6.3.1-1)
- ✓ Click **Search**
- ✓ The Results will show the pharmaceutical from the MMQC message. The completed date is automatically filled upon all customers and Logistics having responded with a notify quantity (see Figure 6.3.1-2). If Completed Date is not populated, then pharmacy staff must go to the QA Details tab to research any customers awaiting response
- ✓ Click **QA Details Tab** (see Figure 6.3.1-3)
 - This tab shows all DMLSS customers that had a customer catalog record for the specific drug. The **Notify Qty** column shows the quantity found on-hand (for that drug and Lot number)

The screenshot shows the 'QA RECORD SEARCH' window in the DMLSS/Inventory Management system. The 'QA Search' tab is active. The search criteria include: Reject Ind: Yes (selected), No; DOD Calendar Year: (empty); Commodity Type: Supply (selected), Equip; Item ID: (empty); Item Desc: (empty); Equip Nom: (empty); Mfg Name: (empty); Mfg Cat No: (empty); QA Ref No: (empty); DOD Ref No: (empty); Ser/Lot No: (empty); ECN: (empty); OA Action: (empty); Problem: (empty). The 'OA Source' is set to 'FDA' and the 'NDC' is '00182219166', which is circled. The 'Limit' is set to 500. The window has a menu bar (File, Edit, Data, Navigate, Utilities, Window, Help) and a toolbar with various icons. On the right side, there is a vertical toolbar with icons for Search, Print, Print List, View MMQ, Close, and Help Topics.

Figure 6.3.1-1: National Drug Code Search Screen

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Item Desc: GENASYME 40 MG 0.5 ML DROPS
 Item ID: 00182219166
 Mfg Cat No: [blank]
 Mfg Name: IVAX/GOLDLINE
 OA Ref No: 082531393001001
 DOD Ref No: DOD-MMQC-08-1393
 Type: ALERT
 Problem: MFR IS VOLUNTARILY RECALLING THE FOL MATL. REASON: INCORRECTLY CALIBRATED
 Desc: DROPPER, DISP: COMPLY W MFR DIST INSTRS IF RECD. EXAMINE INVENTORY IMMEDIATELY

Org ID	Cust ID	Assm ID	Notify Qty	Serv	FDA	Unserv	Rep	Susp	Sp Proj	Serv	Assm
N68094	DAAAR00		0	0							
N68094	DAAA000		0	0							
N68094	DAAAJ00		0	0							
N68094	DAAAB00		0	0							
N66099	DAAAX00		0	0							
N68094	DAAAN01		0	0							

Records 1 to 6 of 9

Figure 6.3.1-2: Completion Date Response Screen

Item Desc: SIMETHICONE 40MG 0.6ML DROPS SUSP 30
 Item ID: 00182219166
 Equip Nom: [blank]
 Mfg Name: IVAX/GOLDLINE
 Mfg Cat No: [blank]
 OA Ref No: 082531393001001
 DOD Ref No: DOD-MMQC-08-1393
 Model No: [blank]
 OA Action: [blank]
 Problem: MFR IS VOLUNTARILY RECALLING THE FOL MATL. REASON: INCORRECTLY CALIBRATED
 Desc: DROPPER, DISP: COMPLY W MFR DIST INSTRS IF RECD. EXAMINE INVENTORY IMMEDIATELY
 Completed Dt: 10/06/2008
 Select All Apply Date

Comm. Type	OA Ref No	DOD Ref No	Completed Date	Item ID	Lot No.
SUPPLY	082531393001001	DOD-MMQC-08-1393	10/06/2008	00182219166	EBD005 FBD001

Records 1 to 1 of 1

Figure 6.3.1-3: Drug Recall Detail Screen

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6.3.2 Review Inventory Management QA – Alert Item Qty On-Hand

When a customer responds with a quantity on-hand greater than zero, the pending action message is posted in the Inventory Management In Box for QTY ON-HAND.

The value would show in the QA record search. If material is on-hand, the site must follow the recall disposition instructions. A pending action is shown for the Main Pharmacy and/or QA IM manager to ensure that clinics and customers are following these disposition instructions.

The steps for completed Item Qty On-hand disposition are:

- ✓ Go to **IM** module
- ✓ From **In Box** select **QA ALERT. ITEM QTY ON-HAND** (see Figure 6.3.2-1)
- ✓ Click **Jump To**
- ✓ Review recalled item Qty On-hand (see Figure 6.3.2-2)
- ✓ After researching recalled item, select **Delete**. The pending action will also clear upon deleting of specific item notice

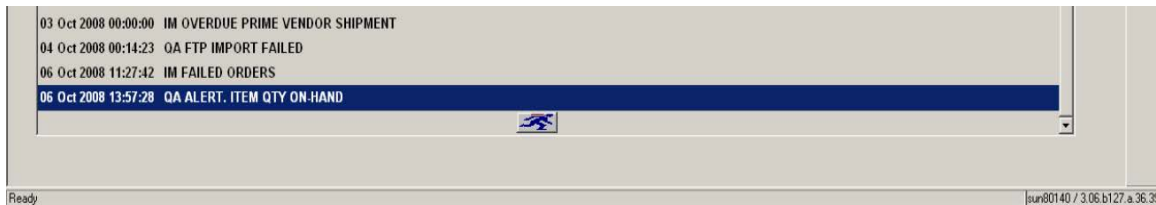


Figure 6.3.2-1: In Box QA Alert Item Qty On-Hand Screen

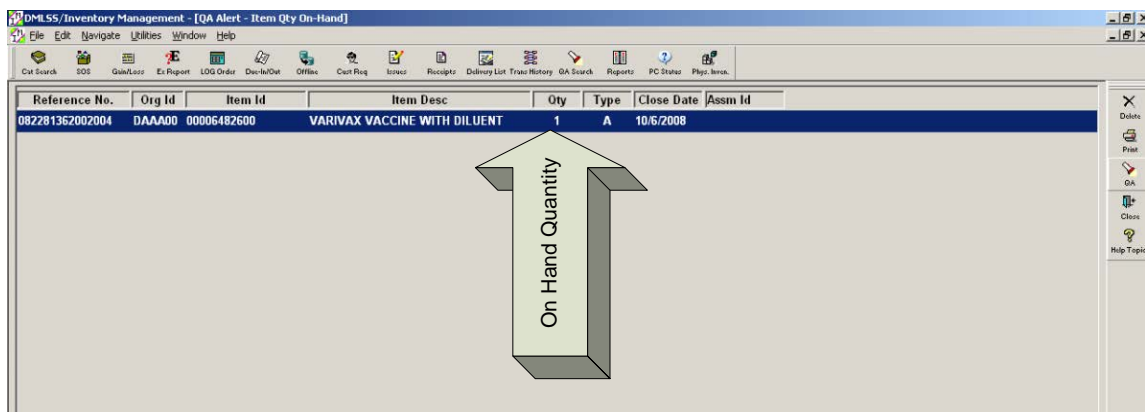


Figure 6.3.2-2: QA Alert Item Qty. On-Hand Screen

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6.3.3 Review Inventory Management QA – Alert Missing or No Item ID Match

DMLSS compares data embedded within the DoD MMQC recall message with catalog records. A pending action is created when a message contains a NDC, a National Stock Number (NSN), a Universal Product Number (UPN), a Manufacturer Part Number or a Manufacturer Catalog number that does not match a DMLSS Catalog. Pharmacy staff responsible for MMQC messages must review the unmatched messages to determine if the item(s) contained within the message match an existing MTF catalog record. If there is no match, pharmacy staff shall close the message by entering the QA action field and filling in the complete date.

The steps to search for recalls that do not match Catalog Items are:

- ✓ Go to **IM** module
- ✓ From In Box select **QA Alert Missing or No MTF Item ID Match**
- ✓ Click **Jump To**
- ✓ Scroll across to the QA NSN column and sort
- ✓ Highlight the item row and research to see if the item is a DMLSS Customer catalog record
- ✓ Conduct a **DMLSS Catalog Search** based on item description, NDC, vendor item number by right clicking any of these fields and selecting copy
- ✓ Select **Cat Search** and paste the copied selection in the corresponding field
- ✓ Select **Search**
- ✓ Document in the **QA Action field action performed**
- ✓ Click **Completed Dt field** and select current date (see Figure 6.3.3-1)
- ✓ **Highlight specific record to be closed out**
- ✓ Select **Apply Date**
- ✓ Click **Save**

If a match is found through the Catalog Search process, pharmacy staff must use the following steps to assign the unmatched Drug Recall notice to the specific DMLSS catalog record. DMLSS will route the MMQC drug recall message to all customers with that ITEM for review.

- ✓ Select **Item ID dropdown** and Click on researched Catalog record or (see Figure 6.3.3-2)
- ✓ Type the **Item ID number** and then select the appropriate Catalog record

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QA Search | **QA Rejected Records** | **QA Details**

Item Desc: RABIES VACCINE USP STER FREEZE DRIED 1-VIAL/SINGLE

Item ID: [Blank]

Equip Nom: [Blank]

Mfg Name: SANOFI-AVENTIS

Mfg Cat No: [Blank]

QA Ref No: 082551396002002

DOD Ref No: DOD-MMQC-08-1396

Model No: [Blank]

QA Action: [Blank]

Problem Desc: SANOFI-AVENTIS AND NOVARTIS RABIES VACCINES ARE IN DELTA EXTREME EMERGENCY STATUS DUE TO THE UNUSUALLY HIGH DEMAND IN AUGUST AND THE ALREADY SHORT SUPPLY OF THE VACCINE.

Completed Dt: 10/06/08 00:00:00

QA Source: FDA

NDC: [Blank]

UPN: [Blank]

NSN: 6505015536713

Type: ALERT

Rec Date: 09/13/2008

Class: Class II

Comm. Type	QA Ref No	DOD Ref No	Complete Date	Item ID	Lot No.
SUPPLY	082551396002002	DOD-MMQC-08-13	10/06/2008		ALL
SUPPLY	082331370001001	DOD-MMQC-08-13			
SUPPLY	082251352001008	DOD-MMQC-08-13			
SUPPLY	082471383001001	DOD-MMQC-08-13			
SUPPLY	082191345001008	DOD-MMQC-08-13			
SUPPLY	082271356001001	DOD-MMQC-08-13			
SUPPLY	082181342001013	DOD-MMQC-08-13			

Figure 6.3.3-1: Item No Match Close Out Screen

QA Search | **QA Rejected Records** | **QA Details**

Item Desc: ALBUMIN HUMAN USP 5% 250ML VIAL

Item ID: [Blank]

Equip Nom: [Blank]

Mfg Name: 00407141310

Mfg Cat No: 00407141360

QA Ref No: 00407270703

DOD Ref No: 00409114401

Model No: 00409114402

QA Action: [Blank]

Problem Desc: MFR HAS ISSUED A VOLUNTARY WITHDRAWAL FOR FOL MATL. REASON: INADEQUATE DOCUMENTATION OF STORAGE AND HANDLING PRIOR TO SHIPMENT. DISP: COMPLY WITH MFR INSTRUCTIONS.

Completed Dt: [Blank]

QA Source: FDA

NDC: [Blank]

UPN: [Blank]

NSN: [Blank]

Type: [Blank]

Rec Date: [Blank]

Class: [Blank]

Comm. Type	QA Ref No	DOD Ref No	Complete Date	Item ID	Lot No.
SUPPLY	082313170001001	DOD-MMQC-08-13			26N9P21
SUPPLY	082191345001008	DOD-MMQC-08-13			
SUPPLY	082381375001001	DOD-MMQC-08-13			
SUPPLY	082471384001005	DOD-MMQC-08-13			
SUPPLY	082411381001001	DOD-MMQC-08-13			
SUPPLY	082481388001004	DOD-MMQC-08-13			
SUPPLY	082251355001019	DOD-MMQC-08-13			

Figure 6.3.3-2: Item Recall Catalog Match Screen

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6.3.4 Review Inventory Management QA – New Records

The steps for sites that wish to capture QA Notices and Alerts from the manufacturer through DMLSS New QA Record functionality are:

- ✓ Go to **IM** module
- ✓ Select **Navigate, QA** and click **New QA Record**
- ✓ Complete the **QA Action** field (see Figure 6.3.4-1)
- ✓ Click **Save**

The screenshot displays the 'DMLSS/Inventory Management - [QA Record - (New)]' window. The form is organized into several sections. At the top, there's a header bar with menu options like File, Edit, Data, Navigate, Utilities, Window, and Help. Below this is a toolbar with various icons. The main form area contains the following fields and sections:

- Item ID:** A dropdown menu.
- Item Desc:** A text field containing 'ALBUMIN HUMAN USP 5% 250ML VIAL'.
- QA Ref No:** A text field containing '08007800110000'.
- QA Type:** A dropdown menu set to 'ALERT'.
- QA Source:** A dropdown menu set to 'LOGISTICS'.
- QA Actions:** A dropdown menu set to 'NOT LOCATED-NO ACTION NEEDED'.
- Mfg Name:** A dropdown menu set to 'AMERISOURCE'.
- Mfg Cat No:** A text field.
- Problem Desc:** A text area containing 'MFR ISSUED A VOLUNTARY WITHDRAWAL. REASON: INADEQUATE DOCUMENTATION OF STORAGE AND HANDLING'.
- Rec Date:** A text field containing '02/13/2009'.
- NDC:** A text field containing '00001880012'.
- NSN:** A text field.
- UPN:** A text field.
- Supply/Equipment:** Radio buttons, with 'Equipment' selected.
- Items Available:** A table with columns 'Select', 'Item ID', 'Item Desc', and 'Lot Number'. The 'Lot Number' column contains the value '1234879'.
- Add/Edit:** A button next to the 'Lot Number' field.

On the right side of the window, there is a vertical toolbar with icons for New, Save, Revert, Print, Add Desc, Add ECU, Close, and Help Topics.

Figure 6.3.4-1: New QA Record Screen

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6.3.5 Review CAIM DMLSS QA Alert Item Quantity Required Customer

DMLSS electronically routes any and all MMQC messages that match the DMLSS Customer catalog record. When a Customer catalog is matched, the Pending Action posts to that specific customer's DMLSS In Box. Pharmacy staff is required to respond to all messages or a delinquency notice will be posted to their In Box.

The steps for CAIM Processing QA Alert Item Qty Required Customer are:

- ✓ Select the **Customer Area Inventory Management (CAIM)** module
- ✓ Select **Customer ID**
- ✓ Highlight the Pending Action – **QA ALERT. ITEM QTY REQUIRED CUST (SUPPLY)**
- ✓ Click **Jump To**
- ✓ All open QA records requiring customer input are listed (see Figure 6.3.5-1). Pharmacy staff may scroll through the Problem Description or, for the full detailed recall message, click the **VIEW MMQC** icon and enter the DoD QA reference number to access the message
- ✓ Highlight specific Drug Recall message
- ✓ Click **Lot Number**
- ✓ Click **OK**
- ✓ Scan shelves and storage location to determine quantity on-hand
- ✓ Enter **On-hand Quantity** in the **Notify Qty** column (See Figure 6.3.5-2)
- ✓ Click **Save**

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DMLSS/CAIM - DAAA00/MAIN PHARMACY - [QA RECORD SEARCH]

File Edit Data Navigate Utilities Window Help

QA Search QA Records QA Details

Item Desc: GENASYME 40 MG 0.6 ML DROPS
 Item ID: 00182219166
 Mfg Cat No:
 Mfg Name: IVAX/GOLDLINE
 QA Ref No: 082531393001001 QA Source: FDA
 DOD Ref No: DOD-MMQC-08-1393
 Type: ALERT
 QA Action:
 Problem Desc: MFR IS VOLUNTARILY RECALLING THE FOL MATL. REASON: INCORRECTLY CALIBRATED DROPPER. DISP: COMPLY W/MFR/DIST INSTRS IF RECD. EXAMINE INVENTORY IMMEDIATELY

NSN:
 NDC: 00182219166
 UPN:
 Rec Date: 09/11/2008
 Closing Dt: 00/00/0000
 Notify Qty:

Comm. Type	QA Ref No	DOD Ref No	Org ID	Cust ID	Notify Qty
SUPPLY	082281359001001	DOD-MMQC-08-1359	DAAA00		
SUPPLY	082281362002004	DOD-MMQC-08-1362	DAAA00		
SUPPLY	082281362001004	DOD-MMQC-08-1362	DAAA00		
SUPPLY	082381373001001	DOD-MMQC-08-1373	DAAA00		
SUPPLY	082381376001001	DOD-MMQC-08-1376	DAAA00		
SUPPLY	082531393001001	DOD-MMQC-08-1393	DAAA00		

Figure 6.3.5-1: Open QA Item Record Screen

DMLSS/CAIM - DAAA00/MAIN PHARMACY - [QA RECORD SEARCH]

File Edit Data Navigate Utilities Window Help

QA Search QA Records QA Details

Item Desc: METHENAMINE MD 500 MG TABLET
 Item ID: 52152011102
 Mfg Cat No:
 Mfg Name: ACTAVIS
 QA Ref No: 081761270022046 QA Source: FDA
 DOD Ref No: DOD-MMQC-08-1270
 Type: ALERT
 QA Action:
 Problem Desc: ACTAVIS HAS ISSUED A RECALL ON FOL MATL. REASON: LACK OF STABILITY INDICATING METHODS. DISP: COMPLY W/MFR/DIST INSTRS IF RECD. IMMEDIATELY QUARANTINE AND

NSN:
 NDC: 52152011102
 UPN:
 Rec Date: 06/26/2008
 Closing Dt: 00/00/0000
 Notify Qty:

Comm. Type	QA Ref No	DOD Ref No	Org ID	Cust ID	Notify Qty
SUPPLY	080111013001001	DOD-MMQC-08-1013	DAAA00		
SUPPLY	060681064001001	DOD-MMQC-06-1064	DAAA00		
SUPPLY	081371189001001	DOD-MMQC-08-1189	DAAA00		
SUPPLY	081761270022046	DOD-MMQC-08-1270	DAAA00		8
SUPPLY	061771178002008	DOD-MMQC-06-1178	DAAA00		
SUPPLY	082191344002003	DOD-MMQC-08-1344	DAAA00		

Records 19 to 24 of 90

Ready | sun80140 / 3.06.b127.a.36.3c

On Hand Quantity > 0

Figure 6.3.5-2: On-Hand Quantity Screen

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6.4 Manage Drug Shortage

Drug shortages can negatively impact drug therapy, compromise patient care, and result in medication errors. Pharmacy staff should manage drug shortages to minimize negative operational and clinical impacts of drug shortages. The following processes provide pharmacy staff with guidelines for managing and minimizing the impact of drug shortages.

6.4.1 Conduct Operational Assessment

6.4.2 Conduct Therapeutic Assessment

6.4.3 Analyze Impact of Shortage

6.4.4 Communicate Finalized Plan

6.4.5 Implement Plan

6.4.6 Drug Shortage Resolution

To return to the Table of Contents, click [here](#).

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6.4.1 Conduct Operational Assessment

When a drug shortage is identified, pharmacy staff should complete the following steps to conduct an operational assessment of the shortage:

- ✓ Validate details of the drug shortage. Details may include name of drug, reason for shortage, anticipated resolution date, available therapeutic alternative(s) and related shortages. Validation options can include the following resources:
 - Refer to the FDA's [Current Drug Shortage Index](#) for current drug shortage lists provided by manufacturers.
 - The American Society of Health System Pharmacists (ASHP) also maintains a list to keep the public informed of the most current drug shortages. The [ASHP Listing of Current Drug Shortages](#) serves as an additional resource.
 - Refer to the [CDC Vaccine Shortage and Delays Website](#) for information about vaccine supplies and guidance if facing vaccine shortages or delays.
 - Communicate directly with PV or Secondary PV and/or reference all materials received by the vendors.
 - Communicate directly with manufacturers to gather additional information as needed.
- ✓ Determine on hand stock by counting on hand inventory.
- ✓ Determine additional available supply by consulting with PV, DLA and all other sources of supply to determine available quantities.
- ✓ Determine purchase history and/or true use history by consulting DMLSS demand/usage reports.
- ✓ Estimate the time to impact on the health system by comparing stock on hand and the available supply from vendors to demand history.
- ✓ Compare estimated time to impact to anticipated resolution date.
- ✓ Determine alternative supply sources and drug products if needed. Alternative drug products should be verified through the substitution catalog (including alternative dosages or manufacturers). Availability must also be verified with the PV.

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6.4.2 Conduct Therapeutic Assessment

A therapeutic assessment should be conducted to determine the clinical impact of all drug shortages that are identified during the operational assessment. To conduct a therapeutic assessment, a pharmacist should complete the following steps:

- ✓ Identify primary patient population affected.
- ✓ Identify therapeutic alternatives by consulting with prescribers, nursing staff and P&T Committee as needed.

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6.4.3 Analyze Impact of Shortage

A Pharmacist should analyze the impact of the drug shortage. To conduct the analysis, a Pharmacist should complete the following steps:

- ✓ Consider therapeutic differences.
- ✓ Coordinate with prescribers for changes in prescribing processes.
- ✓ Communicate any prescription distribution changes to affected patients.
- ✓ Prioritize patients affected by shortage as needed.
- ✓ Consider changes in administration processes.
- ✓ Consider financial ramifications by comparing cost differences of alternative medications.

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6.4.4 Communicate Finalized Plan

Pharmacy staff should communicate a finalized mitigation plan to all individuals and areas of the hospital that are impacted by the shortage to ensure appropriate coordination. Pharmacy staff should adhere to the following guidelines to ensure communication is efficient and comprehensive:

- ✓ Communicate medication shortages and outages to medical staff via CHCS. Additional communication channels may include: P&T, Inpharmation, Command Note, Emails to relevant department heads, Pharmacy Supply SharePoint updates.
- ✓ All communications should include the following information:
 - Name of drug
 - Reason for shortage
 - Anticipated resolution date
 - Available therapeutic alternative(s)
 - Related Shortages
 - Temporary guidelines
 - Temporary procedures
 - Status changes as needed

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6.4.5 Implement Plan

To conclude the pharmacy's response to drug shortages, the pharmacy staff should implement the finalized drug shortage plan. During implementation, pharmacy staff should complete the following steps:

- ✓ Implement information systems changes (e.g. changes within CHCS, Essentris, ADCs, Smart Pumps) and make changes as necessary. Information system changes can include comments in CHCS such as "Drug A shortage, Try drug B."
- ✓ Implement technological changes (e.g. update and print bar codes) and make updates as necessary.
- ✓ Implement inventory system (e.g. DMLSS) changes and make updates as necessary.
- ✓ Implement additional procedures as necessary.

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6.4.6 Drug Shortage Resolution

Once the supply of the drug is available, the pharmacy staff should ensure that the shortage resolution is communicated and system changes are edited. After the drug shortage is resolved, pharmacy staff should complete the following steps:

- ✓ Communicate medication shortage resolution to medical staff. Communication channels may include: P&T, Command newsletters to medical staff, Command Note, Emails to relevant department heads and other stakeholders, Pharmacy Supply SharePoint updates.
- ✓ Revise technological changes (e.g. updated bar codes, CHCS comments) and make updates as necessary.
- ✓ Revise inventory system (e.g. DMLSS) changes and make updates as necessary

Navy Pharmacy SOP: Administrative Operations

7.0 ADMINISTRATIVE OPERATIONS

The Administrative Section of the Navy Pharmacy Standard Operating Procedure (SOP) provides guidelines and procedures that supplement the other Sections of this SOP. Eight Critical Duties exist related to administrative operations:

7.1 [General Administrative](#)

7.2 [Personnel Management](#)

7.3 [Patient Privacy](#)

7.4 [Automated Dispensing Cabinets \(ADCs\)](#)

7.5 [Continuity of Operations Plan \(COOP\)](#)

7.6 [Equipment Maintenance](#)

7.7 [Safety Procedures](#)

7.8 [Inspections](#)

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7.1 General Administrative

General administrative policies, procedures, and information are applicable to Navy Pharmacy staff:

7.1.1 [Mission, Vision, Values](#)

7.1.2 [Hours of Operation](#)

7.1.3 [Scope of Services](#)

7.1.4 [Pharmacy Access](#)

7.1.5 [Generic Medication](#)

7.1.6 [Committee Involvement](#)

7.1.7 [Resource Management](#)

7.1.8 [Navy Pharmacy Command Structure](#)

7.1.9 [BUMED Critical Initiatives and Business Metrics](#)

7.1.10 [Pharmacy Management Reports](#)

7.1.11 [Lot Number Generation](#)

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7.1.1 Mission, Vision, Values

The mission, vision, and values of Navy Pharmacy are as follows:

- The Navy Pharmacy Mission is: “To deliver a robust pharmacy benefit in an economically sound manner.”
- The Navy Pharmacy Vision is: “As advocates of patient-centered care for warriors and warrior families, we shall lead in world class pharmaceutical care delivery.”
- The Navy Pharmacy Values are those held by the Navy including Honor, Courage and Commitment. Navy Pharmacies provide patient-centered care for the men and women who serve and have served our nation along with their beneficiaries.

7.1.2 Hours of Operation

Pharmacy hours of operation are determined by each Command. Active involvement by pharmacy leadership is encouraged in decisions related to establishing pharmacy hours of operation.

Outpatient pharmacies shall provide pharmacy services to patients through the full range of operating hours. All prescriptions shall be accepted for processing up until the time of closing of the pharmacy. For example, if pharmacy closes at 19:30 and a patient arrives at 19:29:59 with ten hardcopy prescriptions, that patient shall be fully served, not told to return the next day. Refer to [7.2.4 Duty Hours](#) for additional information related to overtime for civilian employees.

Outpatient pharmacy hours of operation must be communicated clearly to patients through materials including the use of postings within the pharmacy waiting area, on the Command’s website, and via AudioCare. Such information should include the following:

- Weekday hours
- Weekend hours
- Holiday hours
- Other events that affect pharmacy hours of operation, such as required trainings and Command functions.

The Pharmacy Department Head is responsible for ensuring that the Command’s policy on pharmacy hours of operation is provided. Please embed your Command policy below.

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7.1.3 Scope of Services

Navy pharmacies provide pharmaceutical care, medication dispensing and counseling to patients. The scope of services provided at individual pharmacies varies, and is determined by Command leadership and capabilities.

A pharmacy's scope of services will correspond to the services provided by the Military Treatment Facility (MTF). Examples of pharmacy scope of service include, but are not limited to:

- Ambulatory Clinic
- Infusion Center
- Inpatient
- Outpatient
- Refill Pick-up Location

7.1.4 Pharmacy Access



[MM03.01.01/3](#)

Pharmacy space shall be considered as a "Restricted Access Area." Pharmacy staff and other authorized personnel (as determined by the Pharmacy Department Head) are the only occupants allowed to enter the pharmacy unescorted. All other visitors will be seen by the Pharmacy Department Head or their representative by appointment only, at the discretion of the Pharmacy Department Head.

Pharmacy doors will remain locked at all times. If locked with a combination lock, the lock combination shall be known only by pharmacy staff designated by the Pharmacy Department Head and shall be changed on a frequent basis as defined below:

- Yearly, OR
- When any pharmacy staff member ceases employment, OR
- Upon any suspected compromise of the combination.

Pharmacy windows will be secured after normal business hours and opened only for emergencies. Facilities with emergency departments may leave a window open to service these patients as long as a pharmacy staff member is present in the pharmacy and there are signs communicating the use of that window to patients.

The vault is restricted to authorized personnel, as determined and documented by the Pharmacy Department Head. Only those persons who have official business to conduct may enter. The vault shall be closed and locked at all times. The lock combination shall be changed:

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- Every six months, AND
- Upon change in custodian, AND
- Upon any suspected compromise of the combination.

Meetings with Pharmaceutical Representatives

When permitted by Command, meetings between pharmacy staff and pharmaceutical industry representatives must be approved by the Pharmacy Department Head. There is no requirement to meet with pharmaceutical representatives; any such meetings are not to impact the pharmacy's ability to conduct business and manage workload.

Pharmacy staff may not accept pharmaceutical samples from industry representatives for dispensing to patients. Pharmaceuticals considered for addition to the formulary are to follow the established evaluation process by the Command Pharmacy and Therapeutics (P&T) Committee. Pharmacy staff engaging in meetings with pharmaceutical industry representatives are expected to perform independent research on the pharmaceutical in question before presenting it for P&T evaluation.

The Navy Inspector General provides [guidance](#) related to giving and receiving gifts. Additionally, pharmacy staff should consult with the local legal department and refer to medical staff bylaws for further guidance.

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7.1.5 Generic Medication

The use of brand-name medications is generally discouraged at Navy pharmacies, so as to alleviate patient safety concerns regarding the inability of pharmacy automation to support the use of brand-name medications.

There is a mechanism for the prescriber to indicate that medical necessity requires the use of manufacturer-specific medication. In the event such a request is made, the prescriber will provide justification and the request will be indicated on the medication label in either the drug name OR the SIG.

Refer to TRICARE's [Policy on Generic Medications](#) for additional guidance on generic medications.

Note: Pharmacies are not required to fill civilian prescriptions that indicate “Dispensed as Written,” or “DAW.”

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7.1.6 Committee Involvement



[MM02.01.01/1](#)

[MM02.01.01/2](#)

[MM02.01.01/3](#)

[MM02.01.01/4](#)

[MM02.01.01/5](#)

[MM02.01.01/7](#)

[MM02.01.01/9](#)

[MM02.01.01/12](#)

[MM05.01.13/2](#)

Each parent MTF is required to have a P&T Committee for the purposes of evaluating the relative safety and effectiveness of medications, and of advising the Commanding Officer (CO) on the selection and use of medication within the MTF, as well as within Command clinics.

These local P&T Committees are subject to the formulary management decisions as set forth by the [Department of Defense \(DoD\) P&T Committee](#).

Active pharmacy staff involvement in the P&T Committee is required. The P&T Committee is a formal link between the pharmacy and medical staff. All matters pertaining to the use of medications within the MTF and Command clinics must be reviewed and approved by the committee at least annually. This includes establishing and managing the medication formulary (to include medication strengths and doses), establishing and managing the medication override list for automated dispensing cabinets (ADCs), and communicating drug shortages and substitution protocols to medical staff who participate in medication management. The command will make the formulary accessible to medical staff via CHCS and other means. Sample medications are not required to be on the formulary.

In coordination with the P&T Committee, the medical staff will develop, approve, and implement written medication substitution protocols to be used in the event of a medication shortage or outage. Medication substitution protocols for shortages or outages will be communicated to all medical staff who participates in medication management.

The P&T Committee should also establish a process to select, approve, and procure medications that are not on its formulary list or list of medications available for use. Refer to [6.1 Manage Pharmacy Supply](#) for examples of processes for procuring medications that are not on the formulary list or list of medications available for use.

The Pharmacy Department is encouraged to provide representation on other committees within the MTF that involve medication procurement, dispensing and/or administration. Examples of such committees include, but are not limited to:

- CPR
- Disaster Preparedness and Emergency Management
- Infection Control
- Medication Management
- Risk Management
- Wounded Warrior

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7.1.7 Resource Management

Budget Execution

Pharmaceutical expenditures represent the third largest budget item behind labor and contract services for the Navy Bureau of Medicine and Surgery (BUMED). It is crucial for the Pharmacy Department Head to have a solid understanding of the Resource Management and Budget processes to enable a close working relationship with the site Resource Manager. The Pharmacy Department Head and pharmacy supply staff should execute their authorized funds by ordering the required pharmaceuticals to meet their mission and patient needs. Pharmacy Department Heads should develop a close working relationship with their local Comptroller/Director of Resources Management to encourage robust, bi-directional communication.

BUMED receives their funding via the Congressional Appropriations process. BUMED manages numerous appropriations; however, the two primary ones that Navy Pharmacy should be aware of are:

- Operation and Maintenance, Defense Health Program (O&M, DHP)
- Other Procurement, Defense Health Program (OP, DHP)

The largest appropriation for BUMED is the O&M, DHP which is a 1-year appropriation. (e.g., FY12 funds must be spent before end of FY12.) Occasionally, pharmacy staff might have OP, DHP funding which would typically be related to an equipment purchase. OP, DHP funding is a 3-year appropriation. Typically, OP funds are executed for BUMED through the Naval Medical Logistics Command, Fort Detrick, MD, for purchases of equipment or systems with an acquisition cost in excess of \$250,000.

Each MTF receives an Annual Planning Figure (APF) with which the Regions and Commands create a complete and executable spending plan. This plan data is collected and uploaded to the Summarized Management Analysis Tool (SMART), so that obligation rates can be measured and execution rates analyzed. Resource Management uses Fund Administration and Standardized Document Automation System (FASTDATA), SMART and Standard Accounting and Reporting System-Field Level (STARS-FL) to track spending for the MTFs, the branch clinics and, their respective departments. The Pharmacy operating target (OPTAR) includes a Defense Medical Logistics Standard Support (DMLSS) authorization, which is electronically transmitted from FASTDATA to the DMLSS system and provides pharmacy supply staff their spending target.

[6.0 Supply Operations](#) provides the detailed ordering and receiving process for pharmaceuticals. Embedded into the supply process are the underlying financial data elements that are used to track the pharmaceutical spending by each pharmacy clinic. Budget staff ensures that the appropriate Job Order Number (JON) is assigned to the DMLSS pharmacy customer. The Pharmacy supply staff then ensures that each pharmacy DMLSS catalog record is coded with the correct JON and the pharmacy Expense Element '4'. The expense element (EE) code is a one position alpha or numeric code used to identify the type of resource being consumed. (i.e., EE4 = Pharmacy, EET = Supplies).

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Additional key financial items include:

- STARS-FL: Accounting System for the United States Navy
- Medical Expense and Performance Reporting System (MEPRS): Provides uniform reporting of expense, manpower, & workload for DoD MTFs
 - Pharmacy functional cost code = DAA
 - Pharmacy workload feeds into the Workload Assignment Module (WAM) within Composite Health Care System (CHCS) which feeds into the Expense Assignment System (EAS)
- Budget Allocation Group (BAG):
 - BAG-1 – In-House/Direct Care

Note: Pharmacy dollars are within BAG 1

 - BAG-2 – Private Sector Care
 - BAG-3 – Consolidated Health
 - BAG-4 – IM/IT
 - BAG-5 – Management Activities
 - BAG-6 – Education & Training
 - BAG-7 – Base Ops & Communications

Managers' Internal Control Program (MICP)

The [Federal Managers' Financial Integrity Act of 1982](#) requires all managers to establish effective internal controls and report on their effectiveness. Pharmacy is a critical element of Navy Medicine's mission to provide high quality care to beneficiaries and totals approximately \$500 million per year; it is also one of the largest line items in BUMED budget. The BUMED MICP program coordinator develops and distributes to the regional MICP coordinators the BUMED MICP guidance to document the internal controls each fiscal year.

The Pharmacy Department Head should ensure that annual MICP guidance that requires pharmacy input is completed in an accurate and timely manner. Prior year pharmacy examples from the MICP program are a pharmacy questionnaire and a pharmacy inventory validation exercise.

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7.1.8 Navy Pharmacy Command Structure

Navy Pharmacy operates under BUMED, which is led by the Navy Surgeon General. Navy Pharmacy is led and represented at BUMED by the Navy Pharmacy Consultant/Navy Pharmacy Specialty Leader. The organizational chart depicted in Figure 7.1.8-1 illustrates the full Navy Pharmacy Command structure.

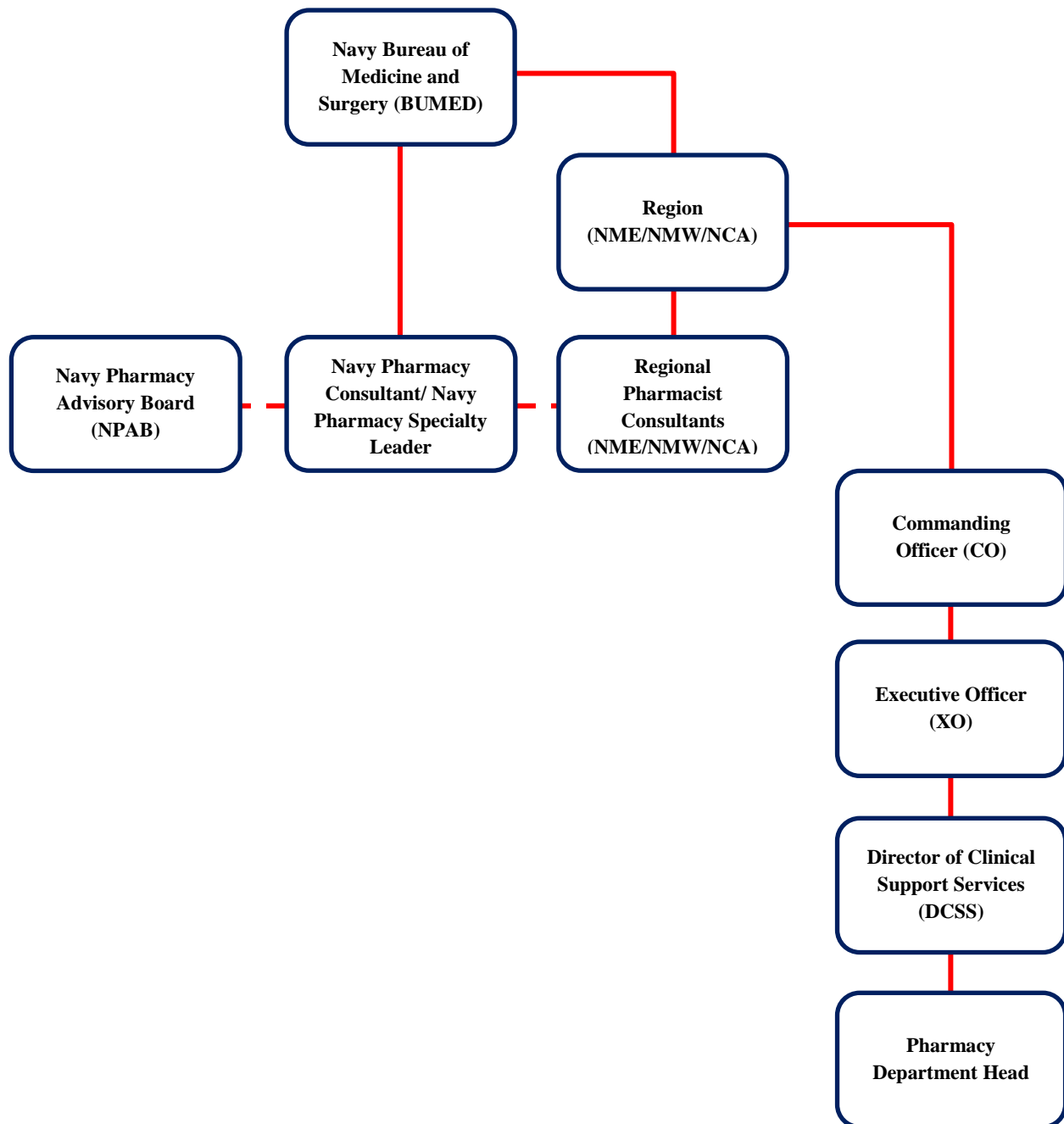


Figure 7.1.8-1: Navy Pharmacy Command Structure

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7.1.9 BUMED Critical Initiatives and Business Metrics

On an annual basis, BUMED and the Regions develop Business Plans. As part of the Business Plan development process, critical initiatives are identified by various stakeholders. In the past, the Navy Pharmacy Consultant has identified mandatory critical initiatives for the pharmacy program that must be addressed within the Business Plan.

The Pharmacy Department Head must submit their pharmacy's approach for meeting any mandatory critical initiative that applies to Navy Pharmacy. Additionally, the Pharmacy Department Head should promptly and accurately respond to any Business Plan and critical initiative taskers that come from the Regions' Business Plan staff.

7.1.10 Pharmacy Management Reports



[MM08.01.01/4](#)
[MM08.01.01/5](#)
[MM08.01.01/6](#)

The Pharmacy Department Head shall utilize available electronic reporting functions (e.g., CHCS, Pyxis) to manage the Pharmacy Department and maintain a workflow consistent with Navy Pharmacy standards. Pharmacy staff may also utilize locally-generated ad-hoc reports, if available. Pharmacy staff shall review appropriate literature and other external sources to learn about best practices and take action on opportunities for improvement in its medication management system. Automated solutions (e.g., OmniCell, Pyxis, ScriptPro) and new technologies should be utilized as appropriate to evaluate near misses and minimize dispensing errors.

Refer to [Appendix H – Pharmacy Management Reports](#) for further information on the following reports:

- CHCS Reports
 - Note: For a complete list of standardized reports available through CHCS, refer to the CHCS Online Users Manual “OLUM.” To access the manual, type “OLUM” from any Menu display in CHCS.
- Department of Defense Pharmacoeconomic Center (PEC)/Pharmacy Operations Center (POC) Reports

7.1.11 Lot Number Generation

Pharmacy staff shall use the following equation to generate lot numbers:

[four digit of year]+[two digit of month]+[two digit of day]+[# of unit dose product for that day]+ [n=narc/control, c=outpatient compound, u=inpatient unit dose and i=IV batches]

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7.2 Personnel Management

Navy Pharmacy personnel are staffed within the pharmacy based on pre-determined requirements and Command needs. Navy Pharmacy personnel are expected to perform specified duties and conduct themselves in a professional and responsible manner.

7.2.1 Pharmacy Department Organizational Structure

7.2.2 Staffing Requirements

7.2.3 Position Descriptions

7.2.4 Duty Hours

7.2.5 Personnel Information Reporting

7.2.6 Professionalism and Conduct

7.2.7 Personnel Management Issues

7.2.8 Training and Credentialing

To return to the Table of Contents, click [here](#).

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7.2.1 Pharmacy Department Organizational Structure

The Pharmacy Department Head leads the pharmacy department and reports to appropriate MTF leadership. The Pharmacy Department Head is responsible for determining the organizational structure of the pharmacy department in consultation with Command leadership and in consideration of applicable staffing requirements.

Figure 7.2.1-1 below provides a sample template for the organizational structure of the pharmacy department. Commands may elect to insert the organizational structure for their pharmacy department on the following page. **If so, the Pharmacy Department Head is responsible for ensuring that the organizational structure for the pharmacy department is provided or embedded below.**

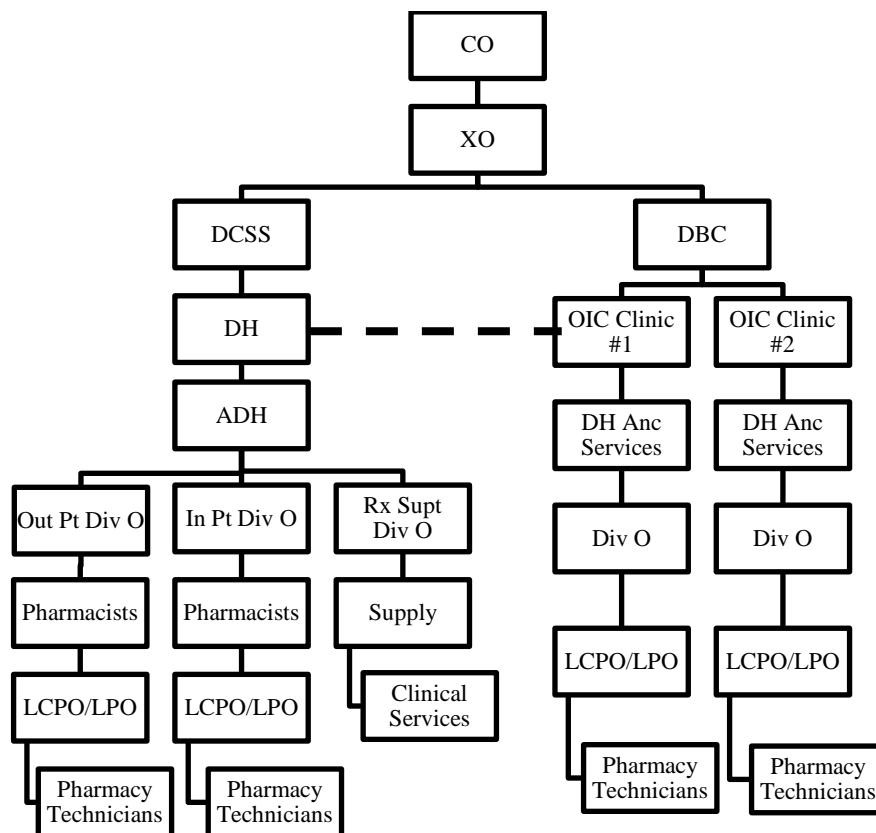


Figure 7.2.1-1: Pharmacy Department Organizational Structure

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7.2.2 Staffing Requirements

Pharmacy department staff may be comprised of military active duty members, military reserve duty members, general schedule civilians, contract civilians, and volunteers. Positions may be restricted to certain staff types (e.g., military-only) as described in [7.2.3 Position Descriptions](#).

Staffing guidelines, including the number of pharmacists and pharmacy technicians assigned to a pharmacy department, are established by the BUMED Staffing Standard, local need, and resource constraints. The Pharmacy Department Head is responsible for determining the pharmacy's staffing requirements, and should notify Command leadership of appropriate routing if a change in staffing is identified.

7.2.3 Position Descriptions

A number of different staff positions exist within Navy Pharmacy. These positions are filled based on the BUMED Staffing Standard and resource constraints.

It is the responsibility of the Pharmacy Department Head to ensure that personnel are executing the duties and responsibilities of each position properly; however, this does not eliminate individual responsibility in properly executing these duties and responsibilities.

Note: Position Descriptions (PDs) have historically been determined by the department; however the Navy Pharmacy Advisory Board (NPAB) is currently consolidating and standardizing PDs for future use throughout the Navy Pharmacy enterprise.

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7.2.4 Duty Hours

Staff duty hours are determined by the Pharmacy Department Head and Command leadership. Pharmacy staff members must follow Command policy for requesting an adjustment to their scheduled hours. For further information, pharmacy staff should contact the Human Resources Department.

Overtime

Certain procedures apply in overtime situations involving civilian pharmacy staff:

- *Foreseen Overtime:* Civilian staff members must receive approval from the appropriate level of the Chain of Command prior to staying past their scheduled hours. The employee shall submit an overtime or compensatory time request as appropriate and have it approved. Verbal approval is acceptable, to be followed up as soon as possible with written documentation.
- *Unforeseen Overtime:* If an emergency occurs, or to complete patient treatment where lack of continuity of care would otherwise jeopardize patient health (e.g. finishing medication orders that arrived right at closing time), the civilian employee shall remain and complete the order. Immediately at the beginning of the next shift worked, the employee shall submit an overtime or compensatory time request as coordinated with supervisor, including justification (e.g. patient came in 20 seconds before closing with 5 prescriptions, remained to complete order).

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7.2.5 Personnel Information Reporting

The following systems are used to report and monitor labor hours and human resource information for Navy Pharmacy staff:

- *Defense Medical Human Resources System – internet* ([DMHRSi](#)): A web-based tool that captures, tracks, and accounts for all human resources within MTFs in the Military Health System (MHS). Every employee is required to view and update personal information, accurately report labor hours, and enroll in local training using DMHRSi. Data entered into DMHRSi is utilized at the BUMED level to calculate metrics enterprise-wide and is the primary human resource tool.
- *Navy Standard Integrated Personnel System* ([NSIPS](#)): A web-based tool for electronic submission and approval of employee leave time. The system standardizes how leave is submitted, contains built-in rules that prevent mistakes in how leave is charged, and eliminates the use of Personnel Support Detachment in the leave process.
- *Standard Labor Data Collection and Distribution Application* ([SLDCADA](#)): A web-based timekeeping tool that tracks civilian employee hours against their job order numbers and type hour codes for financial and pay purposes. Staff must enter all requests for time off, and hours worked, through SLDCADA. Data derived through the system is used in determining workload dedication and civilian pay.
 - Pharmacy staff must check the Employee Verified Time (EVT) at the required interval, or their time cannot be certified.
- *Wide Area Workflow* ([WAWF](#)): A web-based tool for electronic submission and processing of receiving reports and invoices. This system is used for contractor staff working within the pharmacy department. Possible roles that may apply to these staff members include:
 - Acceptance
 - Invoice
 - Receipt

The Pharmacy Department Head, or designated staff member, is responsible for monitoring and certifying pharmacy staff time and leave request entry within these systems. Refer to your relevant Command-specific policies related to personnel information reporting. For further information, pharmacy staff should contact the Human Resource Office.

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7.2.6 Professionalism and Conduct

Proper professional conduct is essential to pharmacy practice and to the reputation of Navy Pharmacy. Pharmacy staff is expected to conduct themselves in a manner that conveys confidence, as well as concern and respect for patients.

At a minimum, pharmacy staff is to:

- ✓ Treat patients and staff with respect and courtesy at all times.
- ✓ Address patients by rank, if known; otherwise, through the use of a title (e.g., Mr., Mrs., Ms.).
- ✓ Be cognizant of language within the pharmacy; profane conversations are not appropriate.
 - Refer to the Navy Equal Opportunity (EO) Policy, [OPNAV Instruction 5354.1F](#), for further information regarding language in the workplace.
- ✓ Be cognizant of actions taken in view of the dispensing area. Social conversations, including personal phone conversations, and activities unrelated to pharmacy business are not to occur within sight or hearing range of patients.
 - Pharmacy staff shall be familiar with their Command's Disruptive Staff Member Policy. For further information regarding this policy, pharmacy staff should contact the Human Resource Office.
- ✓ Be cognizant of the Patient's Bill of Rights and Responsibilities, which shall be posted outside the pharmacy.
- ✓ Perform negative staff counseling only when in private.

Note: Be aware that local Commands may have a policy dictating the use of the English language in the workplace. If such a policy exists, pharmacy staff should be familiar with its requirements. For further information, pharmacy staff should contact the Human Resource Office.

Food and Drink in the Pharmacy

Food and beverages are only permitted within the areas specified by the Pharmacy Department Head. Food and drink consumption areas are limited to non-medication preparation and dispensing areas that are not in sight of patients. Food and drinks are to be stored in marked refrigerators in the break area only.

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Speaking to Patients

Pharmacy staff will address all patients in a professional manner and according to the following procedures:

- ✓ Pharmacy staff will address all patients with the use of a title (e.g., Mr., Mrs.).
 - Pharmacy staff shall also make every effort to address all Active Duty and Retiree beneficiaries by rank when calling the patient and when serving the patient at the pharmacy window.
- ✓ Pharmacy staff should remain cognizant of the patient's comfort level when discussing health matters. Sensitive topics should be discussed discretely, and patients should be offered a confidential area for discussion if warranted or requested.
- ✓ All patients should be treated courteously and with respect. Should an issue arise, the patient shall be referred to the pharmacy staff member designated to handle customer relations, and follow escalation procedures if needed.

Note: When possible, appropriate translation services will be provided for patients whose preferred language is not English.

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7.2.7 Personnel Management Issues

The Pharmacy Department Head will coordinate with the appropriate Command personnel management office to address any personnel issues that cannot be resolved at the Department level. This may include promotion or disciplinary issues, among other matters. Pharmacy leadership may consult the "Navy Pharmacy Resources for Managers" document, which can be accessed on the [Navy Pharmacy NKO Page](#).

7.2.8 Training and Credentialing

Training and education is important to the development of Navy Pharmacy personnel. The Pharmacy Department Head is responsible for ensuring adequate onboard and in-service training for pharmacy staff, in consultation with Command leadership and respective Regional Pharmacist, when appropriate. Pharmacy staff must keep current with all required trainings, and the Pharmacy Department Head is responsible for ensuring that all required trainings have been completed by their staff.

All pharmacists that are working within a Navy Pharmacy must be appropriately credentialed in accordance with [Credentials Review and Privileging Program \(BUMEDINST 6320.66E Change Transmittal 2\)](#).

Pharmacists in Navy Pharmacies must be actively licensed in one of the 50 United States, the District of Columbia, or Puerto Rico. Pharmacists are expected to maintain licensure through applicable state boards and to provide documentation of completion of the training requirements, as necessary. The Command, in conjunction with the pharmacist, is responsible for maintaining proof of licensure.

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7.3 Patient Privacy

Protecting and supporting patient privacy is critical to the role of pharmacy staff. The [TRICARE Management Activity \(TMA\) Privacy and Civil Liberties Office](#) oversees, and provides information on, the protection of personally identifiable information (PII) and protected health information (PHI) within the MHS.

7.3.1 HIPAA Regulations

7.3.2 Privacy Act

7.3.2 Social Security Numbers (SSN)

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7.3.1 HIPAA Regulations

Pharmacy staff shall remain in compliance with the policies set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including associated updates as mandated by the United States Congress, BUMED, or local Command.

In particular, pharmacy staff shall familiarize themselves with the regulations delineated in the Privacy Rule and Security Rule of HIPAA, and follow applicable policies for the release of medical information.

Updates to HIPAA shall be incorporated into Command policies in a timely manner. These updates will be reflected in the Navy Pharmacy SOP, in accordance with established SOP update procedures.

To access additional information related to HIPAA, refer to [U.S. Department of Health and Human Services Health Information Privacy](#).

7.3.2 Privacy Act

Pharmacy staff shall remain in compliance with the policies set forth in the Privacy Act of 1974, including associated updates as mandated by the United States Congress, BUMED, or local Command.

The Privacy Act protects records that contain personal identifiers such as a name, social security number (SSN), or other identifying numbers or symbols. Pharmacy staff shall familiarize themselves with the regulations outlined in the Privacy Act, and follow applicable policies for the release and management of PII.

Updates to the Privacy Act shall be incorporated into Command policies in a timely manner. These updates will be reflected in the Navy Pharmacy SOP, in accordance with established SOP update procedures.

To access more information related to the Privacy Act, refer to: [U.S. Department of Justice Privacy Act of 1974](#) or [U.S. Department of Health & Human Services](#)

7.3.3 Social Security Numbers (SSN)

Social security numbers (SSN) are being phased out of use as a patient identifier; however, this is an acceptable second identifier for patients until official instruction is provided to indicate otherwise.

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7.4 Automated Dispensing Cabinets (ADCs)



The following processes and procedures pertain to the utilization and management of automated dispensing cabinets (ADCs). Types of ADCs used within the pharmacy, ward, and clinic environments include Omnicell and Pyxis.

7.4.1 [ADC Patient Settings](#)

7.4.2 [ADC Order Entry Management](#)

7.4.3 [ADC Stock Management](#)

7.4.4 [ADC Downtime Procedures](#)

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7.4.1 ADC Patient Settings

When available, pharmacy staff should utilize profiled ADCs to deliver medication in the inpatient environment. Non-profiled machines may be used in outpatient and/or procedural settings.

Profiled ADCs



[MM05.01.13/3](#)

[MM05.01.13/4](#)

Medications stored in profiled ADCs are retrieved under a patient's profile after the patient has been admitted into CHCS. Profiled ADCs require prospective pharmacist review of medication orders, prior to medication removal from the ADC unless a licensed independent practitioner (LIP) controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation. In the absence of a pharmacist, a LIP or nurse with the appropriate documented competencies may perform pharmacist review.

Non-Profile ADCs

Medications stored in non-profiled ADCs are organized by medication within the ADC and are utilized in areas where a LIP controls the ordering, preparation, and administration of the medication or in areas where pharmacist review is not required (i.e., emergency room, injectable contrast in radiology). Refer to [2.4 Order Final Verification](#) for further information on procedures required for order verification.

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7.4.2 ADC Order Entry Management

Medication orders are verified before medications are administered. The intent is to deliver the appropriately-labeled medication dose directly to the patient to reduce the chance of a medication administration error, according to the following procedures:

- ✓ Using provider-entered orders in Essentris, pharmacy personnel will enter orders into CHCS so that stocked medications will be available to remove from the ADC.
- ✓ Ward staff pull medications from the ADC for administration to patients.
- ✓ The inpatient pharmacy shall monitor the use of ADCs to adequately stock the ADCs with medications based on the changing needs of the wards.
- ✓ It is recommended that standard stock medications carry a par level of a 10 day supply and a refill level of a 3 day supply based on the usage rate for each medication at each site.

Medications not routinely stocked in the ADC will be sent from the pharmacy using single-dose packaging (unit dose packaging) whenever feasible.

- ✓ A 24-hour supply of medication should be sent to the ward and stored in the patient specific bin. Controlled medications should never be stored in the patient specific bin.
- ✓ Pharmacy will verify orders each day and refill active orders for another 24 hour period. All unused medications should be removed and returned to the pharmacy.
- ✓ It is recommended that pharmacy staff use the “comment” section in CHCS to indicate the location of patient specific bin or refrigerated items to assist the ward staff in finding the medications.
- ✓ When staffing permits, it is recommended to restrict the use of the patient specific bin for bulk items only (e.g. inhalers, creams, etc). All other unit dose medications should be stocked in the ADCs as non-permanent stock and removed after the patient is discharged. This is strongly recommended for controlled substances as it will minimize the need of paper forms and facilitate retrieval of the medication by ward staff.

For further information on the management of ADCs, pharmacy staff should refer to:

- [ADC Settings and Access](#)
- [ADC Override Medication List](#)

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ADC Settings and Access

All ADCs shall be utilized in accordance with the manufacturer guidelines and the American Society of Health System Pharmacists' (ASHP) document, "[ASHP Guidelines on the Safe Use of Automated Dispensing Devices](#)." For further information on ADC equipment maintenance and manufacturer guidelines, refer to [7.6 Equipment Maintenance](#).

- *ADC Access:* The pharmacy will provide ADC access to ward personnel who demonstrate the proper credentials. Ward personnel must complete the appropriate certification program, as determined by the specific ADC and submit a request for access. In general, credentialed ward staff will have access to remove medications only from ADCs located on their assigned ward. In the event that credentialed ward staff transfers to another ward, their certification will also transfer and they will be given access to remove medications from the ADC on the second ward.

Level of ADC access should differ depending on staff member needs and credentialing. The facility should set up access templates for each peer group establishing the minimum level of medication access necessary to perform functions within their scope of practice. Medications may also be segregated in the ADC to restrict access to only certain types of medications.

- Note: Access to controlled substances stocked in the ADC shall be restricted to licensed practitioners. Corpsmen shall have access only to non-controlled substances stocked in the ADC.

The pharmacy will maintain a list of pharmacy and ward staff with ADC access. This list shall be verified with the appropriate department, division, clinic, or ward supervisors to ensure that individuals listed remain employed within the role under which they were granted access. On a periodic basis, to be determined by the facility, access rosters should be reviewed with nursing representatives to ensure ADC access is limited to current personnel and proper location.

The pharmacy shall terminate access rights to any individual whose change of employment or role status no longer necessitates ADC access. Additionally, when available, ADC settings should be programmed to inactivate accounts that have not been in use for at least 30 days.

It is recommended that pharmacy staff coordinate with ward staff to grant privileges to specific individuals to create temporary accounts for floaters. This is strongly recommended for sites where pharmacy staff members trained in the management of ADC settings are not available at all times.

- *ADC Settings:* The ADC super-user, the person with primary rights to the ADC (often the senior pharmacy technician), will be responsible for changing the ADC settings. Specifically, the super-user will monitor the minimum and maximum medication quantities, override capabilities, and standard stock of the ADC.

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Replenishment of the ADC will be the responsibility of the pharmacy. A Refill Report will be run to identify medications that have fallen below minimum stock levels and need to be refilled. Pharmacy personnel will refill each ADC based on the Refill Report. Refill Reports will be run as frequently as determined by the Pharmacy Department.

ADC Override Medication List

The pharmacy shall develop a medication override list for the entire facility. This list indicates which medications can be pulled from the ADC and administered to patients without a pharmacist's review when a delay would harm the patient in an urgent situation. These orders will be reviewed retrospectively by a pharmacist. Refer to [2.4.1 Final Order Verification-Verify Order Information](#) for the specific verification processes.

It is recommended that staff document the reason why a medication is being overridden at the time of the transaction. A retrospective review of all overridden medications should be conducted daily to verify that a valid reason is provided.

The override medication list shall be determined by the Command P&T Committee. Active pharmacy involvement in the P&T Committee to manage the override list is encouraged.

If applicable, the Pharmacy Department Head is responsible for providing the Command policy on the medication override list(s), as approved by the P&T committee. Please embed your Command policy below.

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7.4.3 ADC Stock Management



All medications stored within ADCs will be in unit dose packaging in the most ready-to-administer form. Medications not commercially available will be pre-packaged in the pharmacy. When possible, medications should be stored in individualized compartments. Open matrix drawers should be reserved for OTC and bulk medications. Controlled substance medications must always be stored in segregated compartments. All medications that are pre-packaged in the pharmacy shall be labeled according to the information found in [2.3.1 Prepare Inpatient Medication Labels](#).

- A record of all pre-pack medications must be maintained. See [Appendix E – Pharmacy Forms and Templates](#) for further information regarding the pre-pack medication log.

The ward may request medication that is external to their normal ward stocking requirements using the following procedure:

- ✓ The ward will submit a ward requisition form to the pharmacy for these orders.
- ✓ The pharmacist shall verify that the request is appropriate before filling the order.
- ✓ Once verified the pharmacy will fill this order or stock in the ward's ADC within 24 hours.
- ✓ It is recommended to restrict the privilege to unload permanent stock to personnel in charge of managing ADC inventory.

See [Appendix E – Pharmacy Forms and Templates](#) for further information about the ward requisition form.

It is recommended that pharmacy staff conduct periodic reviews of changing medication usage patterns for each ADC and propose stock modification to minimize the amount of extra unit doses processed by the pharmacy and to expedite medication access by ward staff.

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7.4.4 ADC Downtime Procedures

When ADCs are non-operational, ward staff shall return operations to a unit dose delivery system until downtime ends.

During CHCS downtime, the pharmacy will set ADCs to allow overrides of all medications from the ADCs in the ward, will enter orders directly into an ADC console, or will provide medications directly to the ward as directed by the Pharmacy Department Head. Once CHCS becomes operational again, the pharmacy will pull an override report and verify that the ward has entered an order for every medication pulled via override while CHCS was down.

In the event of an ADC server failure, the pharmacy will set the ADC to allow overrides of all medications from the ADCs no longer than 10 minutes after the losing communication with the server. It is recommended, where available, to program the settings to allow this process to occur automatically, especially in facilities where pharmacy operations are not continuous all day long. In either case, pharmacy staff should restore the default setting no longer than 10 minutes after the network communications have been restored. Alternatively, the pharmacy may provide all medications directly to the ward.

In profiled areas when medication administration is being excessively postponed due to delays in patient admission or transfer in CHCS, the pharmacy should dispense a single unit dose of any non-overridable medication until the patient is properly admitted.

Should it become necessary to manually open the ADC for patient medication access, the Pharmacy Department Head or designee must be notified. When authorized by the Department Head or designee, pharmacy staff may open the ADC to allow for the removal of patient medications.

For further information on downtime procedures refer to [7.5.1 Downtime Procedures](#).

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7.5 Continuity of Operations Plan (COOP)

All pharmacies shall follow a continuity of operations plan (COOP) to address pharmacy downtime situations that includes the downtime procedures listed below. This COOP shall be tested on an annual basis, at minimum, and revised as needed.

The Pharmacy Department Head shall ensure that this COOP is appropriately aligned with, and incorporated into, the Command COOP.

7.5.1 Downtime Procedures

7.5.2 Emergency Management

To return to the Table of Contents, click [here](#).

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7.5.1 Downtime Procedures

Pharmacy staff shall follow downtime procedures utilizing the steps below. In all downtime situations, the scope of services provided by the pharmacy will be determined by the Command, based on the specific event in question.

If the downtime occurs during normal working hours, contact the Pharmacy Department Head or designee, as well as the Pharmacy System Manager or Medical Information Department (MID) to inform them of the outage. If downtime occurs after normal working hours, contact the MID or the Officer of the Day.

Downtime situations may be the result of either scheduled or unscheduled downtime:

- *Scheduled Downtime:* Scheduled downtime is defined as downtime of one or more hospital information systems planned in advance for either routine maintenance or for an upgrade. Scheduled downtime normally occurs overnight, or at the end of the month, to minimize the interruptions to patient care and pharmacy workflow.
- *Unscheduled Downtime:* Unscheduled downtime is defined as unexpected downtime of one or more hospital information systems, due to equipment failure and/or network issues. Unscheduled downtime prevents operation of the standard pharmacy workflow and can impact patient care. Unscheduled downtime must be addressed to the appropriate personnel immediately.

For further information on specific downtime procedures, refer to the information below:

- [Automated Dispensing Cabinet \(ADC\) Downtime Procedures](#)
- [CHCS Downtime Procedures](#)
- [Computer Downtime Procedures](#)
- [DMLSS Downtime](#)
- [Essentris Downtime Procedures](#)
- [Power Outage Downtime Procedures](#)
- [Queuing Downtime Procedures](#)
- [Telepharmacy Downtime Procedures](#)

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Automated Dispensing Cabinet (ADC) Downtime Procedures

Refer to section [7.4.4 ADC Downtime Procedures](#) for information related to ADC downtime procedures.

CHCS Downtime Procedures

The scope of services provided by the pharmacy during CHCS downtime will be determined by the Command, based on Command capacity, patient population and the pharmacist's clinical and professional judgment.

Refer to [3.2.10 Outpatient Downtime Procedures](#) and [2.2.10 Inpatient Downtime Procedures](#) for information specific to the pharmacy environment experiencing the CHCS downtime.

Computer Downtime Procedures

In the event of computer downtime, pharmacy staff should maintain a supply of blank labels for the following medications:

- IVD
- IVF
- IVP
- Regular medications
- Custom labels, if appropriate

Note: Pharmacy staff may generate labels using the desktop application, or handwrite labels if necessary.

All new orders received during downtime should be processed on paper, in accordance with the following steps:

- ✓ Pharmacist processes the order manually and conducts Order Review.
 - Refer to [2.2 Order Review](#) for further information.
- ✓ Affix the new order to the patient's printed profile.
- ✓ Note the doses and quantity of medication dispensed.
- ✓ Review ADC inventory on the ADC console, if operational.

During computer downtime situations that extend beyond 30 minutes, ADCs, such as Pyxis/Omniceil, shall be placed on Critical Override or medications will be provided directly to the ward as directed by the Pharmacy Department Head. Existing orders will continue to appear

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on the patient's ADC profile, however during the downtime no new orders will cross over to the ADCs.

- Nursing staff should only obtain medications for new orders via Critical Override in instances of emergent need, or when delay in medication delivery would cause harm to the patient. Setting the ADCs to Critical Override will allow nurses to obtain medications for new orders. However, new medication orders should still be delivered to, and filled by, the pharmacy, per the procedures outlined in [2.0 Inpatient Pharmacy Operations](#).

Once the computer systems are operational, pharmacy staff must adhere to the following procedures to document and verify all medications obtained from the ADCs during the downtime:

- ✓ Pharmacy staff enter orders into CHCS
- ✓ Pharmacist conducts retrospective review of these orders.
 - Refer to [2.4 Order Final Verification](#) for further information on pharmacist final verification of an order.
- ✓ Pharmacy staff remove the ADCs from Critical Override

If the pharmacy computer system is not operational prior to the next print cycle, pharmacy staff must automatically batch print labels. In this instance, each pharmacy area should generate their own batch medication list, based on patient profiles.

DMLSS Downtime Procedures

The resolution of DMLSS system issues, such as order transmissions or network connectivity, should be coordinated with DMLSS System Administrator and site Inventory Management (IM)/Information Technology (IT) staff. Furthermore, in preparation for any extended DMLSS downtime (i.e., one business day or more), pharmacy staff should coordinate with Resource and Material Management staff to ensure that proper procedures are followed.

If DMLSS is down for a short duration, pharmacy staff should wait for the software system to become operational and contact the DMLSS System Administrator to verify when system will be back on-line.

Pharmacy staff should reference the following steps in the event that the DMLSS application is down and completely inaccessible to pharmacy staff:

Step 1. Use Prime Vendor Pharmacy (PVP) credit dollars first. Note: If the PVP credit account balance is not sufficient for order, proceed to **Step 4**.

Step 2. Submit a DD 1155 to the Prime Vendor (PV).

- a. Ensure that the order is clearly annotated as a **CREDIT ORDER**

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- b. Assign a **Manual PVP Call Number** set aside for Credit Orders
- c. No financial transaction will be required, as a PVP Credit account is being used

Step 3. Proceed to **Step 7.**

Step 4. If the PVP credit account balance is not sufficient for ordering, submit a DD 1155 to the PV.

- a. Note: An example of a solution for generating a DD 1155 during DMLSS downtime is to research products using the PV's online system and print the list to use as an attachment to the DD 1155.

Step 5. Assign a **Manual PVP Call Number** that has been set aside to use for manual and/or emergency orders.

Step 6. Route through the Resource Management Office for funding approval.

Step 7. Maintain a file with copies of all paperwork until data entry is completed. As always, proof of delivery documents (vendor packing slip/vendor delivery invoice) must be maintained for three (3) years from the final invoice payment.

Step 8. Once DMLSS comes back online, input the order into DMLSS as **Off-Line Non-Submit**. For PVP Credit Orders, ensure **Credit Order** is checked.

- a. Input the corresponding **Manual PVP Call Number**
- b. Ensure all order quantities and prices match the vendor's confirmed and delivered product

Step 9. For **non-PVP Credit Orders**, coordinate with Resource Management to reverse any fiscal entries performed during the manual funding approval process, as DMLSS entry will generate all required financial transactions. Duplicate financial transactions could occur if pharmacy staff does not coordinate with Resource Management staff.

Step 10. Refer to [6.1.4 Receipt Pharmacy Supply Order](#) to ensure that DMLSS receipt transaction is processed.

Essentris Downtime Procedures

Refer to [2.2.10 Inpatient Downtime Procedures](#) for information related to Essentris downtime procedures.

Power Outage Downtime Procedures

The pharmacy must follow Joint Commission guidelines in determining which systems to connect to an emergency power source to prepare for a full power outage situation. At minimum, the following must be connected to an emergency power source:

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- ADCs that are located in 24-hour patient care areas
- Any refrigerator or freezer in which medication is stored
- Clean room

Queuing Downtime Procedures

When established queuing systems are non-operational, pharmacy staff shall utilize paper tickets. In these situations, the pharmacy must communicate the alternate queuing procedures to patients in the waiting room.

When scope of services and patient population allow, emergency room patients, active duty patients in uniform or on work status, and patients being discharged from the inpatient facility shall be prioritized ahead of all other patients. In such circumstances, every effort shall be made to maintain continuity of service for all other patients to mitigate disproportionate wait times.

Telepharmacy Downtime Procedures

The scope of services provided during downtime by Remote and Support Telepharmacy sites will be determined by the Command, based on Command capacity, patient population, and the pharmacist's clinical and professional judgment.

When Telepharmacy fails to operate, refer to [4.2.2 Telepharmacy Downtime Procedures](#).

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7.5.2 Emergency Management

In emergency circumstances that prevent the Pharmacy Department from following standard operating procedures, the Pharmacy Department Head will use clinical judgment in authorizing alternate processes in order to meet patient and mission need.

Refrigerator and/or Freezer Failure

Medications that are stored in refrigerators and/or freezers are temperature sensitive, and the failure of refrigerators and/or freezers can result in significant losses. The REES Scientific Centron System is an example of a system that monitors the temperature of refrigerators, freezers and other devices or rooms. This system has an audible alarm that sounds as soon as any connected equipment exceeds its predetermined temperature range and indicates the equipment in question. The system can also notify predetermined users (via phone, pager, etc.) about the status of each monitored device in a room.

In the event of a refrigerator or freezer failure or power outage, pharmacy staff shall comply with the following steps:

- All action steps taken to resolve refrigerator and/or freezer failure situations should be documented appropriately.
- Keep the refrigerator and/or freezer door closed.
 - Refrigerator temperatures shall be maintained at 35° F to 46°F
 - Freezer temperatures shall be maintained at 5°F or below.
- Utilize adhesive tape to secure the door and avoid an accidental opening.
- Record the current temperature.
- Plug the refrigerator and/or freezer into a red plug or a plug that is connected to a backup generator (refrigerators should always be plugged into emergency plugs).
 - Note: Red plugs are powered by the backup generator.
- Contact the appropriate system administrator to report the incident and the action steps taken.
- For information regarding potential medication damage (i.e. acceptable duration of storage at room temperature) pharmacy staff should contact the manufacturer.
 - For information on selected medications and their acceptable durations at room temperature, refer to [Room-Temperature Storage of Medications Labeled for Refrigeration](#), published in the American Journal of Health-System Pharmacy (Volume 64|August 7, 2007).

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- Chart the temperature of the refrigerator and/or freezer every thirty minutes.
 - Note: If the temperature change approaches unsafe levels (within 2°F of any temperature standard of the stored medication), pharmacy staff shall prepare to relocate any affected medications and/or vaccines into proper storage containers to an alternate refrigerator.
- Once power has been restored and the temperature has maintained the required range for a 24 hour period, any items that were removed during the power outage or failure can be returned.

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7.6 Equipment Maintenance

Pharmacy equipment shall be maintained according to manufacturer-suggested guidelines and schedules. This may include following manufacturer-established procedures for resolving the situation, or contacting the manufacturer representative.

For all equipment that is maintained under a central maintenance and support agreement, no configuration movement of system components should be done without expressed written consent of the program manager (PM) at the Navy Medicine Information Systems Support Activity (NAVMISSA), who is responsible for that system. In many cases, the system vendor must be contacted about any changes to, or movement of, systems and a service ticket must be logged. The vendor may need to provide phone support and/or a field engineer to support maintenance. If appropriate procedures are not followed, unauthorized changes made by a local MTF could violate warranties and cause the local MTF to pay for any adverse outcomes, in addition to paying for a replacement system or components. The current systems on a central support contract include Innovations, Omnicell, Optifill, Parata, Pickpoint, Pyxis, and Scriptpro.

For more information, contact the NAVMISSA pharmacist or the system PM at [NAVMISSA](#).

In all circumstances, contact the Pharmacy System Manager or MID for guidance on how to proceed before performing any equipment or system maintenance or relocation. If any equipment or system undergoes physical repair, the MTF Biomedical Equipment Maintenance Division should be alerted. All maintenance activities shall be appropriately documented.

Note: No equipment may be purchased without permission from NAVMISSA.

7.6.1 Manufacturer Contact Information

7.6.2 Equipment Cleaning

7.6.3 Automation Optimization

7.6.4 Automation Restocking

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7.6.1 Manufacturer Contact Information

When an equipment or system maintenance issue arises within the pharmacy, pharmacy staff should contact the appropriate manufacturers to request support, in coordination with the Pharmacy System Manager and/or MID.

Table 7.6.1-1 provides general contact information for various pharmacy equipment and system manufacturers. Commands may have specific manufacturer representatives, or alternate contact information, designated to assist with maintenance issues. Pharmacies may use additional equipment or systems, and should use the space provided in Table 7.6.1-1 to document contact information for the appropriate manufacturer representatives.

Manufacturer Contact Information	
Equipment/System	Contact Information
AHLTA	
AudioCare	
CHCS	
Essentris	
FillMaster	
Innovation Solutions	
MediDose	
OmniCell	
Optifill	
Parata	
Pyxis	
QFlow Queuing System	
Q-Matic Queuing System	
ScriptPro	
Temperature Monitoring System (e.g., Rees/Tempsys)	

Table 7.6.1-1: General Manufacturer Contact Information

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7.6.2 Equipment Cleaning

Equipment can slow or cease from normal operation when dust or other materials are present. All equipment shall be cleaned according to manufacturer-posted timelines. Additional cleaning and sterilizations shall occur as needed.

Equipment cleaning records shall be maintained to ensure they meet timelines supplied by the manufacturer.

7.6.3 Automation Optimization

All pharmacy equipment that can be optimized shall be, according to manufacturer specifications and pharmacy workflow. This includes using available data when determining which medications to stock within automation machines.

7.6.4 Automation Restocking

All pharmacy equipment that requires restocking shall follow manufacturer directions. When restocking medications, refer to the procedures outlined in [3.3.1 Prepare Automation-Filled Prescription](#).

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7.7 Safety Procedures

Pharmacy staff members shall be encouraged to exercise good safety practices while at work in accordance with the Command Safety Program, as well as the [Occupational Safety and Health Administration \(OSHA\)](#), [National Institute for Occupational Safety and Health \(NIOSH\)](#) and the [Hazardous Drugs Safety and Health Plan \(BUMEDINST 6570.3\)](#).

7.7.1 Pharmacy Safety

7.7.2 Hazardous Material Program

7.7.3 Patient Safety Program

7.7.4 Medication Packaging

7.7.5 Investigational Protocols

7.7.6 Acid Locker and Flammable Locker Contents

7.7.7 Disposal of Pharmaceutical Waste

7.7.8 Expired Medication

7.7.9 Infection Control

7.7.10 Personal Property

7.7.11 Abandoned Property

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7.7.1 Pharmacy Safety

Navy and local instructions provide guidelines, procedures and regulations for the implementation of the Occupational Safety and Health Program, Safety Program, Hazardous Drug Program, and Management of Medical Waste. For further information, refer to the following:

- [Hazardous Drugs Safety and Health Plan \(BUMEDINST 6570.3\)](#)
- [Navy Occupational Safety and Health \(NAVOSH\) Program Manual \(OPNAVINST 5100.23E\)](#)

Safety is everyone's responsibility. Any unsafe or unhealthful situation should be brought to the attention of the immediate supervisor for resolution. The goal is to create and maintain as safe an environment as possible for patients and pharmacy staff alike.

The following information provides the method by which the Pharmacy Department safety procedures are taken from paper to practice and the specific actions to be accomplished to ensure a safe working environment:

- The department should appoint a Safety Officer or Safety Petty Officer.
- The Division Safety Officer/Petty Officer will be responsible for ensuring the following actions are accomplished and documented:
 - Perform monthly safety walk-through of spaces to check for safety violations, e.g., fire doors not propped open; aisles not blocked; Fire Bill and Evacuation Plans are posted and current; flammables stored in proper locker, etc.
 - Review at divisional quarter's proper fire reporting procedures, location of extinguishers and alarms.
 - Conduct simulated Fire Drills within their division in accordance with local instruction.
 - Ensure all necessary Material Safety Data Sheets are in place proximal to flammable locker and reviewed at quarters.
 - Review and ensure all personnel are familiar with proper procedures for handling and disposal of HAZMAT. Ensure hazardous materials are being disposed of in accordance with written procedures.

In addition, the following circumstances require that additional safety practices be followed:

- [Electrical Safety](#)
- [Exposure and Incident Reporting](#)

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- [Fire Safety](#)
- [High-Alert Medications \(HAM\)](#)
- [Look-Alike/Sound-Alike \(LASA\) Medications and Confused Drug Names](#)
- [Safety Inspections](#)
- [Safety Training](#)

Electrical Safety

All electrical medical equipment should be checked annually with regards to electrical safety by Medical Repair. No unauthorized electrical equipment may be used within the department. All equipment, including personal radios, must be Underwriters Laboratory (UL) approved and have the UL label attached. For electrical safety, extension cords are not authorized for use within the department except as approved by the Safety Department.

Exposure and Incident Reporting

All accidents resulting in injury or damage to government property must be immediately reported to the Pharmacy Department Head or appropriate supervisor and handled in accordance with [OSHA](#) guidelines.

Any workplace exposure record created in connection with hazardous drug handling shall be kept, transferred, and made available for at least 30 years. Medical records shall be kept for the duration of employment plus 30 years. This is in accordance with the Access to Employee Exposure and Medical Records Standard ([29 CFR 1910.1020](#)).

Fire Safety

Fire safety discussions should be held periodically at weekly quarters to review fire procedures with departmental staff. Fire Bills should be posted in all divisions. All staff should familiarize themselves with the exact location of fire alarm boxes. Consider posting an Evacuation Plan in each division.

Trash shall be removed as needed, at least daily, to minimize the potential fire hazard. Material shall not be stored on top of shelving unless it is 18 inches from overhead sprinklers.

High-Alert Medications (HAM)

High Alert Medications (HAM) are those medications that have been identified as being involved in a high percentage of errors and which carry a more significant risk of causing serious patient harm when used in error.

This list will include concentrated electrolytes. Concentrated electrolytes will only be present in patient care areas when deemed necessary for immediate use. They will be returned to the pharmacy for disposition or properly disposed of once the need no longer exists. The pharmacy shall implement safeguards to prevent inadvertent administration whenever possible.



[MM01.01.03/1](#)

[MM01.01.03/2](#)

[MM03.01.01/9](#)

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A comprehensive list of high-alert medications is available from the Institute of Safe Medical Practices (ISMP) [List of High-Alert Medications](#).

The Command is responsible for developing a list of HAMs, based on local utilization patterns. **The Pharmacy Department Head is responsible for ensuring that this list of HAMs is provided.** The command is also responsible for establishing a process, via the P&T Committee, for managing these HAMs; an example of a process can include the use of warning screens in ADC systems. Please embed your Command policy below.

Look-Alike / Sound-Alike Medications and Confused Drug Names



[MM01.02.01/1](#)

[MM01.02.01/2](#)

[MM01.02.01/3](#)

[MM04.01.01/4](#)

MTFs will maintain a list of look-alike/sound-alike (LASA) medications and confused drug names that are stored, dispensed, or administered on-site. Pharmacy staff will follow Command policies for preventing confusion of LASA medications and confused drug names. These policies may include, but is not limited to, the following:

- ✓ Providing both the brand and generic drug name on LASA medication records
- ✓ Storing products with look-alike or sound-alike names in different locations
- ✓ Affixing stickers that alert pharmacy staff to areas where LASA products are stored. Examples of appropriate labeling include “Name Alert” and “LASA.”
- ✓ Changing the appearance of LASA product names on pharmacy labels, computer screens, shelf labels, bin, and medication records by highlighting, through use of bold face, color, and/or tall man letters, the parts of the drug names that are different
 - E.g. hydr**OXY**zine; hydr**AL**Azine
- ✓ Encourage patients and direct care staff to question pharmacists and nurses about medications that are unfamiliar or look/sound different than expected

A comprehensive list of LASA medications and confused drug names is available in the ISMP's [List of Confused Drug Names](#).

The Command is responsible for developing a list of LASA medications and confused drug names, based on local utilization patterns. The Command must review and update this list on an annual basis.

The Pharmacy Department Head is responsible for ensuring that this list of LASA medications and confused drug names is provided. Please embed your Command list below.

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Safety Inspections

Safety inspections are conducted monthly by the Command Safety Manager. Results of safety inspections and general safety issues are discussed at Pharmacy Department meetings.

Safety Training

Safety training sessions should be scheduled as-needed during weekly departmental quarters. Topics for consideration include:

- Collateral Duty Safety Officer Training
- Fire Safety Coordinator Safety Training
- Hazard Communication
- Interim Life Safety Measures
- Management Safety Training
- Supervisory Safety Training

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7.7.2 Hazardous Material Program

The purpose of the Hazardous Materials Program is to establish procedures for the procurement, storage, use and disposal of hazardous materials. A hazardous material is a substance which potentially affects the health of the user, having properties of flammability, reactivity, toxicity or other special characteristics which make them potentially dangerous if handled improperly.

Hazardous waste must be disposed of in accordance with the [Resource Conservation and Recovery Act \(RCRA\)](#). Staff shall follow local instruction for disposal of hazardous waste. At a minimum, local pharmacy instructions must contain the following guidelines:

- Hazardous waste shall never be washed down sinks or flushed in toilets.
- Environmental Services should be contacted when necessary or at intervals determined by the Pharmacy Department Head to pick up hazardous waste for disposal.
- Hazardous waste items cannot be returned to the Reverse Distributor, unless it is part of the contract, and must be kept separate from other pharmacy stock at all times.

Please consult local instruction and/or [Hazardous Drugs Safety and Health Plan \(BUMEDINST 6570.3\)](#) regarding Management of Medical Waste for specific requirements on disposal of hazardous materials. A comprehensive list of hazardous materials/medications can be obtained from the [National Institute for Occupational Safety and Health \(NIOSH\)](#).

The Command is responsible for developing a list of hazardous materials, based on local utilization patterns. **The Pharmacy Department Head is responsible for ensuring that this list of hazardous materials is provided.** Please embed your Command policy below.

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7.7.3 Patient Safety Program

The DoD Patient Safety Program (PSP) is a comprehensive, centralized program with the goal of establishing a culture of patient safety and quality within the MHS. The Pharmacy plays a big role in the patient safety program at any hospital or clinic. As there are 1.5 million preventable adverse drug events annually in U.S. (IOM 2006) and medication errors represent approximately 50% of all patient safety events reported by military health care facilities, the Pharmacy Department Head must ensure accurate and timely reporting of patient safety events that occur within the pharmacy.

The different types of patient safety events that exist are defined as follows:

- *Adverse Event*: Adverse events are defined as either:
 - *Adverse Drug Reactions*: “Medication prescribed correctly but which has an unanticipated consequence.” OR
 - *Adverse Medication Error* “Medication prescribed incorrectly.”
- *Near Miss*: “An event or situation that could have resulted in harm to a patient, if it had reached the patient.”
- *Sentinel Event*: “Unexpected occurrences involving death or serious physical or psychological injury or risk thereof.”



[MM07.01.03/1](#)

[MM07.01.03/2](#)

[MM07.01.03/3](#)

[MM08.01.01/1](#)

[MM08.01.01/2](#)

[MM08.01.01/3](#)

[MM08.01.01/7](#)

[MM08.01.01/8](#)

BUMED uses the Patient Safety Reporting System (PSR), which is a Web-based tool that enables enterprise-wide reporting of both medication- and non-medication-related patient safety events, including near misses. Events can be entered anonymously or by name. Once a patient safety event is entered into the PSR, the site Risk Manager or Patient Safety Manager will review. If the event is medication related, the Pharmacy Department Head or designee will be requested to review the event and answer questions within the PSR tool.

Pharmacy Department Heads or staff member's expertise may be requested for ongoing sentinel event root cause analyses conducted by Quality/Risk Management office. The P&T Committee will also review patient safety events, which may include evaluating the events and associated trends to identify risk points, levels of performance, patterns, and variations of its medication management system.

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7.7.4 Medication Packaging

Prescription medications for oral use by outpatients will be dispensed in child-resistant containers, unless the patient or prescribing practitioner requests conventional (non child-resistant) closures. These requests for non child-resistant containers shall be documented in the patient's CHCS profile or in automation, if feasible.

Medication packaging which is not child-resistant must be clearly labeled with “this package for households without young children,” and shall only be provided when requested by the patient or prescribing practitioner.

This policy is in accordance with the [Poison Prevention Packaging Act of 1970](#).

Navy Pharmacy SOP: Administrative Operations

7.7.5 Investigational Protocols



[MM06.01.05/1](#)
[MM06.01.05/2](#)
[MM06.01.05/3](#)

If an MTF participates in the Food and Drug Administration (FDA) Investigational New Drug (IND) Program, the pharmacy will follow procedures that comply with [Use of Investigational Agents in Humans \(BUMEDINST 6710.69\)](#), as well as local policies and procedures that govern the IND program's use of new or experimental drugs. The [FDA IND Program](#) is the method through which a pharmaceutical company receives permission to transport investigational drugs across state lines prior to receipt of an approved marketing application.

For information related to the wasting of chemotherapeutic investigational protocols, refer to [Appendix A – Guidelines for Preparation, Handling and Disposal of Chemotherapy and Anti-Neoplastic Orders, Investigational Protocols](#).

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7.7.6 Acid Locker and Flammable Locker Contents

The [U.S. Occupational Safety & Health Administration \(OSHA\) Hazard Communication Standard](#) requires that manufacturers of hazardous chemicals prepare Material Safety Data Sheets (MSDS) and deliver them in conjunction with deliveries of hazardous chemicals. An MSDS is prepared by the manufacturer and details the physical and chemical properties of the hazardous material, as well as guidelines for safe storage.

MTFs that receive deliveries of hazardous chemicals shall file the corresponding MSDS in the pharmacy, in accordance with established policy. Pharmacy staff in pharmacies that use and store such hazardous materials shall have access to the MSDS.

For purposes of pharmacy staff and patient safety, the pharmacy will maintain, at a minimum, the following lockers of hazardous materials:

- [Acid Locker](#)
- [Flammable Locker](#)

Acid Locker

Caustic acids shall be stored in a clearly labeled “Acid Locker.” At a minimum, the following acids, if stocked, shall be stored in the acid locker:

- Concentrated hydrochloric acid
- Concentrated potassium hydroxide
- Glacial acetic acid
- Nitric acid
- Oxalic acid
- Sulfuric acid
- Trichloro-acetic acid

These substances shall be submitted and approved by the P&T Committee prior to being issued to wards, clinics or outpatients. All caustic acids shall be stored in accordance with the information found on the medication’s MSDS.

Navy Pharmacy SOP: Administrative Operations

Flammable Locker

Flammable medications shall be stored in a clearly labeled “Flammable Locker,” following accepted fire safety regulations. Pharmacy staff will ensure that all flammable medications are stored in accordance with the information found on the medication’s MSDS.

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7.7.7 Disposal of Pharmaceutical Waste

The Pharmacy Department is tasked with the safe and proper disposal of pharmaceutical waste. Pharmaceutical waste is produced through several channels including: manufacturer's shelf life expiration, manufacturer's product recalls, manufacturer's defect, unused portions of reconstituted oral and intravenous medicinals, contamination, and medications returned after being dispensed to patient.

Responsibility

Division Officers will ensure that all staff personnel are thoroughly versed with the proper handling and discarding of routine, controlled and biohazard medical waste in accordance with local command policy and pertinent hospital instructions.

Materials and Agents

The following materials and agents should be disposed of in accordance with the appropriate local instruction for Management of Medical Waste:

- Chemotherapeutic agents
- Hazardous waste
- Infectious waste
- Pharmaceutical waste

Procedures for Disposal of Controlled Substances

Controlled substances must be destroyed beyond reclamation to assure that the substance does not become available to unauthorized persons as required by [Title 21 § 1307.21, Disposal of Controlled Substances](#). Pharmacy staff should ensure that wasting procedures followed for disposal of controlled substances align with the standards set forth by the Command's Controlled Substances Inventory Board (CSIB).

Navy Pharmacy SOP: Administrative Operations

7.7.8 Expired, Damaged, and/or Contaminated Medications



MM03.01.01/8

MM05.01.19/1

Pharmacies shall minimize the potential for dispensing expired, damaged, and/or contaminated medication through identification, tracking and removal of expired, damaged, and/or contaminated medication from pharmacy inventory.

All doses must be checked for an appropriate expiration date during preparation and verification, and before administration to a patient.

To ensure appropriate monitoring of expired, damaged, and/or contaminated medications, pharmacy staff shall follow the subsequent inventory management procedures:

- ✓ Pharmacy staff shall conduct a complete pharmaceutical inspection on a monthly basis, at minimum, for all medication storage areas.
 - Refer to [7.8 Inspections](#) for additional information.
- ✓ Damaged and/or contaminated medications that are identified or brought to the pharmacy by hospital staff will be stored separately from medications available for administration.
- ✓ Medications with approaching expiration dates shall be placed in a position to be dispensed first.
- ✓ Medications that will expire within at least 30 days will be removed from pharmacy inventory and stored in a secure area, away from medications to be dispensed, to await return via reverse distribution. Note: The storage area for expired medications will be clearly marked to avoid accidental dispensing.
 - Medications labeled with the month and year of expiration only may be used until the last day of the listed month.
 - Pharmacy staff should take into consideration medications normally dispensed in a 90-day supply or greater, when determining whether a medication is appropriate for dispensing to a patient.

Expired medications will be returned via the appropriate reverse distribution procedures upon receipt of the replacement item. For further information, refer to [6.2 Manage PVP Returns and Credits](#). Unused or returned medications will be returned in accordance with local command policy and pertinent hospital instructions.

Note: Medication expiration dates may only be extended through the U.S. DoD/FDA Shelf-Life Extension Program (SLEP). For more information on using SLEP refer to [Navy Medicine Shelf Life Extension Program \(BUMEDINST 6710.62B\)](#).

Navy Pharmacy SOP: Administrative Operations

7.7.9 Infection Control

Pharmacy Environment

Pharmacy staff will maintain a neat and clean pharmacy environment by following, at a minimum, the subsequent procedures:

- All pharmacy work surfaces should be cleaned and wiped with 70% isopropyl alcohol or other appropriate disinfectant, as needed.
- All floors should be swept or vacuumed daily and mopped at a minimum of twice weekly, or as needed, with an approved disinfectant.
 - It is recommended that local cleaning contracts include cleaning floors within the pharmacy and sterile products areas.
- All waste/trash will be emptied at least daily and more often as necessary to maintain the area in a neat and clean condition.
- All refrigerators will be thoroughly cleaned and maintained at the recommended temperature.
- All robotics and mechanized equipment will be routinely cleaned, in accordance with the procedures found in [7.6 Equipment Maintenance](#).
- Pharmacy staff will prevent the accumulation of bulk containers that impede proper cleaning of the pharmacy area.

In addition, all equipment should be maintained, cleaned and sanitized in accordance with the procedures outlined in [7.6 Equipment Maintenance](#).

Personnel

Pharmacy staff will maintain a neat and clean appearance by following, at a minimum, the following procedures:

- Appropriate attire and closed toe shoes will be worn in the pharmacy at all times.
- Frequent and thorough hand washing is required for all personnel.
 - When available, staff should use alcohol-based hand rub as the primary mode of hand hygiene.
- The use of jewelry will be kept to a minimum.
- Fingernails must be clean
- Hair must be clean and neat.

Navy Pharmacy SOP: Administrative Operations

Sterile Products Program

All sterile products shall be manufactured and handled in accordance with current [USP 797](#) standards.

Sterile compounding should be centralized within the pharmacy, as resources and space permit. Pharmacy staff shall maintain written record of the sterile products program including, but not limited to, the following actions:

- Maintaining laminar flow hood
- Biological safety cabinet (BSC) quality control requirements, to include compliance with cleaning and certification requirements
- Changing high-efficiency particulate air (HEPA) filters when air flow is restricted (as indicated by the continuous monitor) or upon filter contamination
- Preparation of the following:
 - Chemotherapeutics
 - Irrigations
 - Large and small volume intravenous admixtures

Pharmacy staff working in the sterile products area must adhere to the following guidelines, at a minimum:

- No food or drink may be in the sterile products area
- All personnel will wear personnel protective equipment (PPE) at all times that they are present in the clean room, to include a sterile gown, head gear, shoe covers, gloves, and face mask, all disposable. Refer to [8.1.1 Personal Protective Equipment](#) for further information on sterile PPE.
 - MTFs that utilize an enclosed and vented BSC outside of a clean room can disregard the PPE requirement.

Only pharmacy staff with proper competencies in aseptic technique (as determined by the Pharmacy Department) may work in the sterile products area

Refer to [USP 797](#) standards for further information regarding proper sterilization procedures.

Navy Pharmacy SOP: Administrative Operations

7.7.10 Personal Property

It is the responsibility of the ward staff to collect any medications brought by the patient to the hospital at the time of admission. All medications collected in this manner must be appropriately documented, in accordance with Command policy on personal property.

The Pharmacy Department Head is responsible for ensuring that the Command policy on personal property is provided. Please embed your Command policy below.

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7.7.11 Abandoned Property

Medications brought from home may only be retained for use if the provider writes an order stating that the patient may use his or her own medication while admitted. Medications may be returned to the patient upon discharge if authorized by the discharging provider.

Medications not authorized for return to the patient, or remaining after an identified amount of time following patient discharge, shall be destroyed following local destruction procedures and guidance provided in [7.7.7 Disposal of Pharmaceutical Waste](#) and in accordance with the Command policy on abandoned property.

The Pharmacy Department Head is responsible for ensuring that the Command policy on abandoned property is provided. Please embed your Command policy below.

Navy Pharmacy SOP: Administrative Operations

7.8 Inspections



[MM03.01.01/18](#)

Pharmacy staff must inspect, on a monthly basis, all areas that are used to stock, administer, or dispense medications. The purpose of these inspections is to check for expiring or expired medications, excess stock, damaged supply, and adherence to storage and other clinical standards.

7.8.1 Pharmacy Inspections

7.8.2 Ward and Clinic Inspections

7.8.3 General Inspections

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Administrative Operations

7.8.1 Pharmacy Inspections

Pharmaceutical supply maintained within the confines of the pharmacy should be monitored on a regular basis through the use of standard inventory management procedures included in [6.0 Supply Operations](#); however, at minimum, pharmacy staff must conduct formal monthly inspections.

Results of this inspection will be recorded using a Pharmacy Inspection Checklist. Refer to [Appendix E– Pharmacy Forms and Templates](#) for a copy of the Pharmacy Inspection Checklist. The results of the monthly inspection will be reviewed by the departmental leadership (Leading Petty Officer (LPO) / Leading Chief Petty Officer (LCPO) / Department Head (DH)) for comments and corrective action, if necessary.

The pharmacy staff member who completed the inspection must sign the departmental checklist and file it within the pharmacy for a period of one year.

Branch Clinic Technical Assist Visits (TAVs)

Branch Clinic Technical Assist Visits (TAVs) are pharmacy visits performed by the Military Treatment Facility (MTF) Pharmacy Department Head (or designated representative) when the command has professional oversight responsibility for lower echelon branch clinic pharmacies. These visits will be performed on an annual basis, at a minimum, or on a more frequent basis, to be determined by the MTF leadership.

Results of this inspection will be recorded using a Pharmacy Inspection Checklist. Refer to [Appendix E– Pharmacy Forms and Templates](#) for a copy of the Pharmacy Inspection Checklist.

The results of the TAV will be reviewed by the pharmacy department head (if not the inspector) and filed within the pharmacy for a period of two years. Copies of the TAV will be sent to the Director, Branch Clinics, the Clinic Officer in Charge, as well as the senior pharmacy staff member at the clinic pharmacy.

Navy Pharmacy SOP: Administrative Operations

7.8.2 Ward and Clinic Inspections

Pharmacy staff, under supervision of a pharmacist, must conduct monthly ward and clinic inspections to monitor medications maintained outside of the pharmacy environment. Results of this inspection will be recorded using a Ward/Clinic Inspection Record.

Refer to [Appendix E – Pharmacy Forms and Templates](#) for a copy of the Ward/Clinic Inspection Record. If discrepancies are found in the ward or clinic stock, the pharmacy staff shall notify the responsible Ward/Clinic Department Head or Division Officer, in addition to the Pharmacy Department Head, so that corrective action can be taken.

Note: Pharmacy staff will check for expired medications by examining a sampling of medications and reviewing their expiration dates. Leadership of the applicable ward or clinic is responsible for ensuring there are no expired medications in their area, and that their staff manages their stock appropriately.

The pharmacy staff member who completed the inspection, the Ward Division Officer, and one of the following individuals must sign the Ward/Clinic Inspection Record and file it within the pharmacy for a period of one year:

- Pharmacy Department Head
- Division Officer
- Other authorized personnel, as determined by the Pharmacy Department Head

Recording the monthly results of Ward/Clinic Inspections in a Ward Inspection Report provides pharmacies with a method to track a pharmacy's performance over the course of the year to understand and chart areas for improvement. Refer to [Appendix E – Pharmacy Forms and Templates](#) for a template of the Ward Inspection Report.

Navy Pharmacy SOP: Administrative Operations

7.8.3 General Inspections

Various inspections by stakeholders outside the pharmacy may be conducted, as arranged by Command. These inspections may include, but are not limited to, the following:

- CSIB inspections
- Environmental Management Systems (EMS)
- National Committee for Quality Assurance (NCQA)
- Navy Inspector General (IG)
- The Joint Commission (TJC)

The Pharmacy Department Head will coordinate with Command leadership as appropriate to facilitate participation in such inspections. The Pharmacy Department Head is responsible for communicating the guidelines for complying with inspections to pharmacy staff.

Navy Pharmacy SOP: Compounding Operations

8.0 COMPOUNDING OPERATIONS

The procedures stated within this Section of the Navy Pharmacy Standard Operating Procedure (SOP) apply to compounding within sterile and non-sterile environments.

Two Critical Duties exist related to compounding:

8.1 [Sterile Compounded Medication](#)

8.2 [Non-Sterile Compounded Medication](#)

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Navy Pharmacy SOP: Compounding Operations

8.1 Sterile Compounded Medication



MM05.01.07/2

Pharmacists will consult the clear compounding guidelines and pre-packing instructions for all compounded, and prepackaged pharmaceuticals provided in the Draft Department of Defense (DoD) Compounding Pharmaceuticals Recipe Book, which can be accessed on the [Navy Pharmacy NKO Page](#).

Pharmacy staff should consider limiting compounding operations to the preparation of materials that are not commercially available. The [American Society of Health-Systems Pharmacists \(ASHP\) Foundation](#) provides a web-based tool that can be used to evaluate proposals when outsourcing the production of sterile products.

Pharmacy staff will also adhere to applicable [United States Pharmacopeia \(USP\) 797 Guidelines: Pharmaceutical Compounding – Sterile Preparations](#) when performing sterile compounding operations.

8.1.1 Personnel Protective Equipment

8.1.2 Prepare Sterile Compounded Medication

8.1.3 Prepare Chemotherapy and Anti-Neoplastic Medication

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Compounding Operations

8.1.1 Personnel Protective Equipment

Pharmacy staff must wear appropriate personnel protective equipment (PPE) when preparing a compounded sterile product (CSP):

- ✓ Prior to entering the designated compounding area pharmacy staff must remove all outerwear, makeup, jewelry and artificial nails.
- ✓ Pharmacy staff should don PPE according to the following steps:
 1. Shoes or shoe covers
 2. Head and facial hair covers
 3. Face masks/eye shields
 4. Perform hand washing
 5. Non-shedding gown
- ✓ Upon entering the designated compounding area pharmacy staff must perform antiseptic hand cleaning procedures and don sterile, powder-free gloves.

Navy Pharmacy SOP: Compounding Operations

8.1.2 Prepare Sterile Compounded Medication



MM05.01.07/1
MM05.01.07/3

Pharmacy staff responsible for compounding medications must ensure that the sterile preparation is accurately prepared, packaged and distributed. A pharmacist, or pharmacy staff under the supervision of a pharmacist, shall compound or admix all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product's stability is short. Refer to [2.2.5 Must Contact Pharmacist List](#) for further information.

Requirements for preparation of sterile compounds reflect the risk-level associated with the compounded sterile product (CSP). During preparation, pharmacy staff will visually inspect the medication for particulates, discoloration, or other loss of integrity.

CSPs are classified as being for either immediate use or non-immediate use:

- [Immediate Use](#)
- [Non-Immediate Use](#)

Immediate Use



MM05.01.09/1

[USP 797](#) allows CSPs to be prepared (compounded) without the need for special facilities (e.g., clean room or ISO Class 5 hood) and practices (e.g., full cleansing or gowning). Two key criteria for immediate-use exemption are:

1. Avoidance of touch contamination
2. Administration within one hour

Nevertheless, it is prudent to carry out immediate-use compounding in an area that is kept clean and orderly. Additionally, common aseptic techniques should be followed.

The immediate-use provision in USP 797 allows the preparation and dispensing of CSPs without the need to be in compliance with the requirements as stipulated in USP 797 for low-risk level CSPs (e.g., ISO Class 5 hood or isolator, facility design and environmental controls, and personnel cleansing and garbing). However, the handling of immediate-use CSPs must meet all of the following criteria:

- Immediate-use CSPs are used in those situations where there is a need for emergency or immediate patient administration of a CSP.
- Immediate-use CSPs are not intended for storage for anticipated needs or batch compounding.
- Preparations that are medium-risk level (admixtures compounded using multiple additives and/or small volumes, batch preparations (e.g., syringes), complex manipulations (e.g., total parental nutrition (TPN)), or preparation for use over several days) and high-risk level CSPs shall not be prepared as immediate-use CSPs.

Navy Pharmacy SOP: Compounding Operations

- The compounding process involves simple transfer of not more than three commercially manufactured packages of sterile nonhazardous products or diagnostic radiopharmaceutical products from the manufacturers' original containers and not more than two entries into any one container or package (e.g., bag or vial) of sterile infusion solution or administration container or device.
- During preparation, aseptic technique is followed and, if not immediately administered, the finished CSP is under continuous supervision to minimize the potential for contact with non-sterile surfaces, introduction of particulate matter or biological fluids, mix-ups with other CSPs, and direct contact of outside surfaces.
- Unless immediately and completely administered by the person who prepared it, or immediate and complete administration is witnessed by the preparer, the CSP shall bear a label listing patient identification information, the names and amounts of all ingredients, the name or initials of the person who prepared the CSP, and the exact one-hour beyond-use date.
- If administration has not begun within one hour following the start of preparing the CSP, the CSP shall be promptly, properly, and safely discarded.

Non-Immediate Use

CSPs that do not meet the criteria listed above are classified as being for non-immediate use.

To achieve minimal risk of microbial contamination, CSPs for non-immediate use must be compounded with sterile commercial products and materials, through a procedure involving no more than 3 sterile products and no more than 2 entries into each sterile container. Additionally, compounding must occur entirely in an ISO Class 5 environment, and the ISO 5 engineering control must be located within an ISO 7 buffer area.

If conditions are less than ISO Class 5, opened or needle-punctured single-dose containers must be used within 1 hour of compounding. All single-dose containers prepared in an ISO Class 5 environment may be used for 6 hours following needle puncture.

All sterile compounding actions performed by pharmacy staff will be recorded in a Sterile Compounding Log (see [Appendix E – Pharmacy Forms and Templates](#) for further information).

When assigning lot numbers to compounded medications, the lot numbers must be recorded in a Compounded Lot Assignment Book (see [Appendix E – Pharmacy Forms and Templates](#) for further information). Refer to [7.1.11 Lot Number Generation](#) for instructions on generating lot numbers.



Navy Pharmacy SOP: Compounding Operations

8.1.3 Prepare Chemotherapy and Anti-Neoplastic Medication

All chemotherapy agents will be prepared by the pharmacy in a negative pressure environment. Horizontal air flow hoods are not to be used to prepare chemotherapy agents. Chemotherapy preparation will occur in a Class II Type B biological safety cabinet or an appropriately vented and filtered isolator, in accordance with [USP 797](#).

For further information on the preparation of chemotherapy and anti-neoplastic medications, refer to [Appendix A – Guidelines for Preparing, Handling and Disposing of Chemotherapy and Anti-Neoplastic Orders](#).

Navy Pharmacy SOP: Compounding Operations

8.2 Non-Sterile Compounded Medication

Pharmacists will consult the clear compounding guidelines and pre-packing instructions for all compounded and prepackaged pharmaceuticals provided in the Draft Department of Defense (DoD) Compounding Pharmaceuticals Recipe Book, which can be accessed on the [Navy Pharmacy NKO Page](#).

Pharmacy staff will also adhere to applicable [USP 795 Guidelines: Pharmaceutical Compounding – Non Sterile Preparations](#), for procedures related to non-sterile compounding.

8.2.1 Personnel Protective Equipment

8.2.2 Prepare Non-Sterile Compounded Medication

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Compounding Operations

8.2.1 Personnel Protective Equipment

Pharmacy staff must wear appropriate personnel protective equipment (PPE) when preparing a compounded product:

- ✓ Pharmacy staff should don PPE appropriate to the type of compounding being performed. Common components of PPE include, but are not limited to:
 - Head and facial hair covers
 - Non-shedding gown or coat
 - Powder-free gloves
- ✓ When appropriate, pharmacy staff may also wear:
 - Face masks/eye shields
 - Shoes or shoe covers
 - Aprons

Pharmacy staff should exercise clinical professional judgment in determining the appropriate PPE required for compounding non-sterile products.

Navy Pharmacy SOP: Compounding Operations

8.2.2 Prepare Non-Sterile Compounded Medication

Pharmacy staff responsible for compounding medications must ensure that the non-sterile preparation is accurately prepared, packaged and distributed.

Non-sterile compounds must be prepared in a designated compounding environment, with easily accessible hand washing facilities. When appropriate, non-sterile compounds may be prepared in an ISO Class 5 hood. Pharmacy staff should use clinical professional judgment to determine which substances require preparation in an ISO Class 5 environment.

All non-sterile compounding actions performed by pharmacy staff will be recorded in a Non-Sterile Compounding Log (see [Appendix E – Pharmacy Forms and Templates](#) for further information).

When assigning lot numbers to compounded medications, the lot numbers must be recorded in a Compounded Lot Assignment Book (see [Appendix E – Pharmacy Forms and Templates](#) for further information). Refer to [7.1.11 Lot Number Generation](#) for instructions on generating lot numbers.

Navy Pharmacy SOP: Controlled Substance Operations

9.0 CONTROLLED SUBSTANCE OPERATIONS

The procedures stated within this Section of the Navy Pharmacy Standard Operating Procedure (SOP) apply to controlled substance operations. Pharmacy staff will follow these procedures when preparing and filling controlled substance medication orders.

Pharmacies shall monitor Schedule-II medications, through the cycle of receipt, inventory, and dispensing. Sites may elect to do so using the standardized working stock inventory, main vault inventory, requisition, and dispense forms, or using electronic inventory. Additionally, pharmacies should audit and monitor drugs with high potential for diversion (DHPDs) from receipt into inventory, until dispensed to outpatients or administered to inpatients.

Sites that employ hard copy forms to monitor controlled substance inventory should refer to the procedures outlined below while sites that elect to use electronic inventory should follow the applicable procedures.

Four Critical Duties exist related to controlled substance operations:

9.1 [Controlled Substance Prescription Preparation, Filling, and Dispensing](#)

9.2 [Main Vault \(Non-Working Stock\) Inventory](#)

9.3 [Working Stock Inventory](#)

9.4 [Receipt Controlled Substances Order](#)

The Pharmacy Department Head is responsible for ensuring that a list of Command-selected DHPDs is provided. Please embed your Command list below.

To return to the Table of Contents, click [here](#).

Navy Pharmacy SOP: Controlled Substance Operations

9.1 Controlled Substance Prescription Preparation, Filling, and Dispensing



MM05.01.11/2

MTFs shall use the standardized dispense, inventory, and requisition forms to audit and monitor Schedule-II drugs and additional drugs determined by the Commanding Officer (CO) to be treated like a Schedule II drug from receipt into inventory until dispensing and should follow the instructions for electronic inventory provided in the vault functions of the appropriate technology (i.e., Pyxis or CHCS).

The standardized dispense, inventory, and requisition forms (i.e., NAVMED 6710 series form) may be obtained through the official Navy Medicine website:

<http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx>.

For additional information on the uniform audit program for the Controlled Substances Inventory Board (CSIB) at naval medical treatment facilities (MTFs), refer to the [Guidelines for Controlled Substances Inventory \(BUMEDINST 6710.70A\)](#).

For further information on the preparation, verification and delivery of Schedule-II-V inpatient orders, refer to (respectively):

- [2.3.3 Prepare Unit Dose Orders](#)
- [2.4 Order Final Verification](#)
- [2.5.4 Stock Controlled Substance Medication](#)

For further information on the preparation, filling and dispensing of Schedule-II-V outpatient prescriptions, refer to (respectively):

- [3.3 Prescription Filling](#)
- [3.4.2 Verify Schedule-II Medication Prescription](#)
- [3.5.4 Dispense Prescriptions](#)

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Navy Pharmacy SOP: Controlled Substance Operations

9.2 Main Vault (Non-Working Stock) Inventory

Pharmacies that operate their own vault, and that do not utilize the vault as their working stock, shall, at a minimum, conduct a weekly inventory of all Schedule-II medications and a biennial inventory of all Schedule-III-V medications maintained within the vault.

Note: It is recommended that all medications stored within the Main Vault be counted on a weekly basis; however, current policies require only a biennial inventory of these medications.

The pharmacy staff member operating the vault will utilize the following procedures when verifying the inventory count of the pharmacy vault:

- ✓ Print the appropriate CHCS (or equivalent) inventory report and compare the current medication stock to the inventory numbers noted on the inventory report.
- ✓ If the inventory report reflects the medication stock currently in the vault, all medication has been accounted for.
 - The pharmacist will sign the CHCS inventory report to indicate that the count is correct.
- ✓ If the inventory report does not reflect the medication stock currently in the vault, a discrepancy exists.
 - This discrepancy must be resolved immediately. Once resolved, pharmacy staff will print and attach appropriate documentation explaining the discrepancy to the CHCS (or equivalent) inventory report.

All CHCS inventory reports should be filed in the pharmacy for a period of two years.

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Navy Pharmacy SOP: Controlled Substance Operations

9.3 Working Stock Inventory

A pharmacy's working stock is defined as the controlled medication stock from which the pharmacy fills and dispenses prescriptions (e.g., breakout locker or automated system). In most cases, the pharmacy will use its breakout as its working stock; however, in some instances (e.g., clinics) a pharmacy will not have a separate breakout section, and will instead use its vault as its working stock.

9.3.1 Inpatient Working Stock Inventory

9.3.2 Outpatient Working Stock Inventory

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9.3.1 Inpatient Working Stock Inventory

Inpatient pharmacy staff is responsible for inventorying the following components of the controlled substances working stock:

- [Schedule-II Working Stock Inventory](#)
- [Automated Dispensing Cabinets \(ADCs\) Inventory](#)

Schedule-II Working Stock Inventory

The pharmacy staff member responsible for controlled substances must verify the pharmacy's Schedule-II working stock inventory count at the beginning of every shift. Refer to [Automated Dispensing Cabinets \(ADCs\) Inventory](#) for replenishment of controlled substances in the ADC. The following steps must be taken when verifying the pharmacy's working stock inventory count at a minimum of one time a day, every day the pharmacy is open:

- ✓ Verify that the NAVMED 6710/1 matches the current quantity of each medication in the working stock. All open bottles or packages containing controlled substances shall be back-counted and must reconcile with the information on the NAVMED 6710/1.
 - If the working stock inventory recorded on the NAVMED 6710/1 matches the physical back-count, the working stock inventory has been accounted for.
 - If the NAVMED 6710/1 does not match the physical back-count, pharmacy staff must contact the Vault Custodial Officer or the Department Head for resolution. If the Department Head is unable to resolve the discrepancy, the head of the Controlled Substances Inventory Board (CSIB) should be notified.
- ✓ Return unused/unnecessary medications to the main vault as patient need requires.
- ✓ If a medication stock has been entirely depleted, file the corresponding NAVMED 6710/1 form in the main pharmacy vault. This form shall be filed in the vault for two years.
 - Record return of the NAVMED 6710/1 to the main pharmacy vault on the corresponding NAVMED 6710/4.
- ✓ Record completion of narcotic and controlled substance inventory count on the corresponding NAVMED 6710/4 form. See [Appendix E – Pharmacy Forms and Templates](#) to access a copy of NAVMED 6710/4.

If the inventory count of the pharmacy's working stock indicates that the working stock needs to be replenished from the main pharmacy vault, the pharmacy staff member responsible for controlled substances shall follow the subsequent procedures:

- ✓ Communicate with the vault as to who will issue the required Schedule-II medications from the main pharmacy vault to the working stock.

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- The pharmacy staff member working in the vault will fill out a NAVMED 6710/1 for each Schedule-II medication issued to the working stock. The pharmacy must complete a standard NAVMED 6710/1 form for each Schedule-II order to be filled, as well as for locally-selected DHPDs. See [Appendix E – Pharmacy Forms and Templates](#) to access a copy of NAVMED 6710/1.
- The pharmacy staff member responsible for controlled substances will record receipt of the medication on the working stock's NAVMED 6710/4.
- ✓ Secure the Schedule-II medications in a locked storage device.

If the pharmacy receives a controlled substance order for a medication that is not in the working stock, a pharmacy staff member will call, fax or deliver the order to the main vault for filling. The pharmacy staff member operating the main vault will complete a standard NAVMED 6710/1 form for each Schedule-II order to be filled.

Automated Dispensing Cabinets (ADCs) Inventory

ADCs shall be inventoried by the pharmacy department weekly to ensure controlled and DHPD are accurately accounted for. Replenishment of the ADC will be the responsibility of the pharmacy. A refill report will be generated, at a frequency determined by the Pharmacy Department, to identify medications that have depleted below minimum stock levels and need to be refilled. The pharmacy will refill each ADC based on the refill report.

If the refill report indicates that the ADC needs to be replenished, pharmacy staff should use the main pharmacy vault; exceptions can be made as circumstances and patient need require. If the ADC is replenished from the main pharmacy vault, the pharmacy staff member responsible for controlled substances shall follow the subsequent procedures:

- ✓ Communicate with the vault as to who will issue the required Schedule-II-V medications from the main pharmacy vault to the working stock.
- ✓ Refill the appropriate cells in the ADC with the Schedule-II-V medications.

If the pharmacy receives a controlled substance order for a medication that is not in the working stock, a pharmacy staff member will call, fax or deliver the order to the main vault for filling.

Refer to [7.4 Automated Dispensing Cabinets \(ADCs\)](#) for further information regarding ADC medication stock, settings and access.

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9.3.2 Outpatient Working Stock Inventory

Outpatient pharmacy staff is responsible for inventorying the following components of the controlled substances working stock:

- [Schedule-II Working Stock Inventory](#)
- [Automation Inventory](#)

Schedule-II Working Stock Inventory

The pharmacy staff member responsible for controlled substances must verify the pharmacy's Schedule-II inventory count at the beginning of every shift. The following steps must be taken when verifying the pharmacy's working stock inventory count:

- ✓ Verify that the NAVMED 6710/1 matches the current quantity of each medication in the working stock. All open bottles or packages containing controlled substances shall be back-counted and must reconcile with the information on the NAVMED 6710/1.
 - If the working stock inventory recorded on the NAVMED 6710/1 matches the physical back-count, the working stock inventory has been accounted for.
 - If the NAVMED 6710/1 does not match the physical back-count, pharmacy staff must contact the Vault Custodial Officer or the Department Head for resolution. If the Department Head is unable to resolve the discrepancy, the head of the CSIB should be notified.
- ✓ Return unused/unnecessary medications to the main vault as patient need requires.
- ✓ If a medication stock has been entirely depleted, file the corresponding NAVMED 6710/1 form in the main pharmacy vault. This form shall be filed in the vault for two years.
 - Record return of the NAVMED 6710/1 to the main pharmacy vault on the corresponding NAVMED 6710/4.
- ✓ Record completion of narcotic and controlled drug inventory count on the corresponding NAVMED 6710/4 form. See [Appendix E – Pharmacy Forms and Templates](#) to access a copy of NAVMED 6710/4.

If the inventory count of the pharmacy's working stock indicates that the working stock needs to be replenished from the main pharmacy vault, the pharmacy staff member responsible for controlled substances shall follow the subsequent procedures:

- ✓ Communicate with the vault as to who will issue the required Schedule-II-V medications from the main pharmacy vault to the working stock.

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- The pharmacy staff member working in the vault will fill out a NAVMED 6710/1 for each Schedule-II medication issued to the working stock. The pharmacy must complete a standard NAVMED 6710/1 form for each Schedule-II prescription to be filled, as well as for additional Command-selected DHPDs. See [Appendix E – Pharmacy Forms and Templates](#) to access a copy of NAVMED 6710/1.
- The pharmacy staff member responsible for controlled substances will record receipt of the medication on the working stock's NAVMED 6710/4.
- ✓ Secure the Schedule-II medications in a locked storage cabinet.

If the pharmacy receives a controlled substance prescription for a medication that is not in the working stock, a pharmacy staff member will call, fax or deliver the prescription to the main vault for filling. The pharmacy staff member operating the main vault will complete a standard NAVMED 6710/1 form for each Schedule-II prescription to be filled.

Automation Inventory

Replenishment of the automation will be the responsibility of the pharmacy. A refill report will be generated, at a frequency determined by the Pharmacy Department, to identify medications that have depleted below minimum stock levels and need to be refilled. The pharmacy will refill each automation based on the refill report.

If the refill report indicates that the automation needs to be replenished from the main pharmacy vault, the pharmacy staff member responsible for controlled substances shall follow the subsequent procedures:

- ✓ Communicate with the vault as to who will issue the required Schedule-II-V medications from the main pharmacy vault to the working stock.
- ✓ Refill the appropriate cells in the ADC with the Schedule-II-V medications.

If the pharmacy receives a controlled substance order for a medication that is not in the working stock, a pharmacy staff member will call, fax or deliver the order to the main vault for filling.

Note: Schedule-II medications may be stored in a lockable automated device (e.g. automation, Omnicell, Pyxis) in the outpatient pharmacy environment if feasible, provided that the following conditions are met:

- ✓ A perpetual inventory can be maintained.
- ✓ A count on that item can be verified manually prior to release to the ultimate user.
- ✓ Prior to release to the ultimate user two counts must be performed by pharmacy, one of which must be manual.
- ✓ A minimum of one shift count performed per day.

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9.4 Receipt Controlled Substances Order

At all times, there must be a separation of duties between executing and receiving an order. The receipting individual may not be the person who executed the original order. The individual who places the order in DMLSS may not receipt the order within DMLSS or perform the physical receipting count and verification.

Refer to [6.1.4 Receipt Pharmacy Supply Order](#) for further information on receipting, validating, and stowing material.

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Appendix A – Guidelines for Preparing, Handling and Disposing of Chemotherapy and Anti-Neoplastic Orders

The subsequent procedures must be followed when preparing, handling or disposing of chemotherapy and anti-neoplastic orders. These procedures shall be followed in addition to those procedures outlined in [2.0 Inpatient Pharmacy Operations](#).

For chemotherapy/anti-neoplastic orders intended for non-oncological use, standard procedures within [2.0 Inpatient Pharmacy Operations](#) shall be followed.

1. [Process Chemotherapy Orders](#)
2. [Verify Chemotherapy Orders](#)
3. [Personnel Protection](#)
4. [Preparation of Chemotherapy Orders](#)
5. [Compounding Chemotherapy Orders](#)
6. [Stocking Chemotherapy Orders](#)
7. [Disposal of Chemotherapy Orders](#)
8. [Chemotherapy and Anti-Neoplastic Drug Spill Control Procedure](#)
9. [Exposure and Incident Reporting](#)
10. [Investigational Protocols](#)
11. [Surveillance of Occupational Exposure to Chemotherapy Drugs](#)
12. [Required Training for Pharmacy Staff Handling Chemotherapy Orders](#)
13. [Hazardous Drug Control Officer](#)

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Process Chemotherapy and Anti-Neoplastic Orders

A chemotherapy file must be generated and maintained for all chemotherapy patients. Active files will be maintained for a minimum of two years following the last treatment. The file will include the following information:

- ✓ Two patient identifiers:
 - 1) Name AND
 - 2) Date of birth OR social security number (SSN)
- ✓ Patient height, weight, BSA (body surface area), and gender
- ✓ Allergy information
- ✓ Orders
- ✓ Lab verification
- ✓ Compounding sheet
- ✓ Any protocol-supporting documentation

*Drug names
should not be
abbreviated in
patient files and
medication
orders.*

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Verify Chemotherapy and Anti-Neoplastic Orders

All adult orders must have labs verified before the order is prepared to ensure blood counts allow for treatment. If there are no labs more current than seven days prior to treatment, contact the provider or charge nurse. Some pediatric orders do not require this check since certain treatments are meant to obliterate the patient's blood cells. These orders may say "induction therapy" in which case prepare as written. If an order states "maintenance therapy" or "consolidation therapy" check the lab values and contact the case manager if needed.

Only one patient's chemotherapy bags may be placed within each transport bag.

At time of order entry, the pharmacist must verify the order for the following:

- ✓ BSA calculated correctly (if not within 5 percent, contact provider)
- ✓ Dosing calculated correctly (if not within 5 percent, contact provider)
- ✓ Dosing appropriate based on current guidelines and literature
- ✓ Timing of cycles, to ensure chemotherapy treatment is due
- ✓ Route of administration
- ✓ Dosing against the protocol (for pediatric patients)
- ✓ The number of milliliters (mL) of each medication required to compound the order, based on the concentration of each medication
- ✓ All current labs have been checked and recorded

At the time of compounding, the pharmacist must verify the following:

- ✓ Lab results are appropriate for the order
- ✓ Contents in the syringe match the order and the compounding log
- ✓ If diluted contents of the verified syringe are pushed into the correct patient's bag and bag is immediately removed from the hood

Note: This step does not apply to intravenous push (IVP) or intrathecal chemotherapy

- ✓ Bag is labeled and inspected for leaks and particulate prior to being placed in a transport bag

Orders dosed per unit body size must contain the following information:

- **Chemotherapy dose per unit body size**
- **Patient's weight or body surface area**
- **Calculated dose**

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Note: Only the administering physician may pick up intrathecal chemotherapy orders. These orders may only be delivered with other medication intended for administration into the central nervous system.

If the chemotherapy order is found to be complete and correct, the pharmacist will sign the order (for hard copy or PyxisConnect orders) or verify the order electronically (for electronic orders received through Essentris).

Personnel Protection

Pharmacy staff preparing chemotherapy agents shall adhere to the following protective apparel procedures, as well as guidelines set forth by the [Occupational Safety and Health Administration \(OSHA\)](#) and [National Institute for Occupational Safety and Health \(NIOSH\)](#):

- ✓ Don gloves approved for use with anti-neoplastic agents.
 - If chemotherapy-specific gloves are not available, two pairs of powder-free latex surgical gloves may be substituted. Powder will absorb any liquids, keeping it in contact with skin.
 - Any glove(s) should be changed when contaminated or every 3-4 hours, whichever is sooner.
- ✓ Don a disposable gown made of non-absorbent material

Staff members who are pregnant or breast feeding should avoid contact with cytotoxic or biological agents.

Protective respiratory devices are not permitted except in the event of a spill. Respirators must be fitted and personnel trained appropriately before their use. For further information contact the Industrial Health and/or Safety Department, as appropriate.

Food, drink, chewing gum, personal cosmetic products (e.g., makeup, lipstick) are not allowed in the preparation area.

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Preparation of Chemotherapy and Anti-Neoplastic Orders

All chemotherapy agents will be prepared by the pharmacy using negative pressure chemo-isolators. Horizontal air flow hoods are not to be used to prepare chemotherapy agents. Chemotherapy preparation will occur in a Class II Type B biological safety cabinet (or an appropriately placed isolator, in accordance with [USP 797](#)) located in the pharmacy clean room.

Pharmacy staff should be familiar with the capabilities, limitations and proper use of the chemo-isolator and the closed containment system. When using the chemo-isolator, the following procedures must be followed:

- ✓ The hood must be operated and cleaned per manufacturer guidelines
- ✓ The anti-chamber outer and inner doors must be closed
- ✓ No other IV admixtures should be prepared in the chemo-isolator
- ✓ IV sets may be primed in the chemo-isolator, positive pressure isolator, or the horizontal flow hood in a clean room. All primed sets will have a closed system drug-transfer device (CSTD) attached prior to being injected with a chemotherapeutic agent. This allows for essentially needle-free manipulation within the chemo-isolator.

Any drug considered hazardous and requiring special handling as stated by its manufacturer, will also be compounded in the chemo-isolator or hood. The only exceptions would be any compound that would damage the internal hepa filter due to its volatility. The Material Safety Data Sheet (MSDS) should be consulted if there is a question regarding any specific compound.

The entire chemo-isolator or hood will be cleaned with a 70 percent alcohol solution at the beginning and end of each shift, and as needed between preparations. Hoods should also be cleaned immediately after preparation of Bacillus Calmette-Guerin (BCG) or other infectious products. Care should be taken to avoid contact with the filters since they can become damaged. On heavy spills, warm soap and water can be used, rinsed, and then followed by 70 percent alcohol.

In the absence of a closed containment system, negative pressure aseptic technique will be employed. The use of chemotherapy pins where feasible is also encouraged.

All chemotherapy agents should be prepared for pick up in a zip-locked chemotherapy transport bag. Each syringe or bag should be individually labeled. An additional label, cautioning that the bag contains cancer chemotherapy and must be disposed of properly, must be affixed to or printed on the zip locked bag. Transportation will be made in leak-proof plastic containers that contain a lid.

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Compounding Chemotherapy and Anti-Neoplastic Orders

When compounding chemotherapy orders, the subsequent procedures must be followed:

- ✓ All intravenous chemotherapy admixtures that are compounded in IV bags will have primed lines attached and primed with diluent prior to the addition of any chemotherapeutic substance.
 - If it is necessary to prime the line with medication, as is the case with some protocols, then a label will be attached to the line warning that the line contains chemotherapy.
- ✓ Unless exact volume is requested specifically by the ordering physician, all volumes will be standard bag volumes.
- ✓ When preparing IVP medications, the entire dose should be delivered in a syringe(s) that provides the most accurate measurement without compromising safety. If the most accurate measurement is ≥ 80 percent of a syringe volume, then the dose must be divided into smaller doses to provide safe and accurate delivery.
 - When dividing a dose, generate the labels to reflect what is being delivered per syringe and in the CHCS “PRESCRIPTION COMMENTS” field indicate the concentration and what the total dosage will be.
- ✓ Compounded IV or injectable orders will be recorded in the Compound IV or Injectable Order Log. See [Appendix E – Pharmacy Forms and Templates](#) for more information.

Whenever a cytotoxic preparation has been ordered, other than an intravenous admixture or commercially available oral product, it may be extemporaneously manufactured according to the following procedures:

- ✓ Only equipment designated exclusively for chemotherapy use will be used.
- ✓ Whenever a unit dose tablet is not available from a manufacturer it will be packaged using the unit dose packaging procedure. The label will include:
 - Patient information
 - Medication name
 - Lot number
 - Strength
 - Expiration date
 - Filling pharmacist or technician’s name and/or number

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- ✓ Compounded unit dose orders will be recorded in the unit dose packaging log. See [Appendix E – Pharmacy Forms and Templates](#) for further information.
- ✓ Lot assignments for compounded chemotherapy orders made in advance will be recorded in the Compounded Lot Assignment Book (CLAB). See [Appendix E – Pharmacy Forms and Templates](#) for more information.

Stocking Chemotherapy and Anti-Neoplastic Orders

The chemotherapy pharmacy will stock all chemotherapy drugs that require aseptic compounding. No chemotherapy drugs for oncological use will be dispensed from or stored in any clinic, ward or other satellite pharmacy.

Disposal of Chemotherapy and Anti-Neoplastic Orders

Pharmacy staff must follow state-specific requirements and Command Industrial Hygiene instructions for disposal of chemotherapy and anti-neoplastic orders. These requirements include, but are not limited to, the following guidelines:

All materials associated with the chemotherapy dose should be placed in a uniquely-designated sharps waste container. Waste containers will be taped, boxed up and disposed of according to the Command bio-hazardous material guidelines for non-Environmental Protection Agency (EPA)-regulated chemotherapy waste, to include at minimum:

- ✓ Chemotherapy waste containers being delivered to the Inpatient Pharmacy must be securely sealed with biohazard tape.
- ✓ The container must be bagged with 4 millimeter-thick plastic bags clearly identified with a cytotoxic hazard label and colored differently than infectious waste or biohazard bags.
- ✓ This bagged material must then be placed in a chemotherapy box and sealed.
- ✓ Personnel disposing of these containers must wear disposable gowns and gloves.

EPA-regulated waste must be segregated from non-EPA-regulated waste as well as from other EPA-regulated wastes. Puncture-proof plastic containers with lids are to be used. A layer of absorbent material is to be placed at the bottom to sufficiently handle any potential leaks. Once the container is filled, it shall be properly sealed, taped, and boxed if necessary.

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Chemotherapy and Anti-Neoplastic Drug Spill Control Procedure

In the event of a drug spill, pharmacy staff must follow, at minimum, the subsequent control procedures.

Note: The American Society of Health-System Pharmacists (ASHP) defines a “small spill” as any spill less than 5 mL, and a “large spill” as any spill of 5 mL or more. [OSHA](#), [NIOSH](#) and the [Hazardous Drugs and Safety Health Plan \(BUMEDINST 6570.3\)](#) provide additional guidance related to responding to small and large spills.

- ✓ Secure area of spill.
- ✓ Do not allow anyone to enter or traverse the area since this will spread the contaminant.
- ✓ Utilize the proper personnel protective equipment (PPE) when participating in spill control.
- ✓ Refer to the manufacturer’s Material Safety Data Sheets (MSDS) for proper clean-up. As an alternate procedure, complete the following steps:
 - Control the spread of the spill with the absorbent by covering the spill. Cover all of the contaminant.
 - Collect all liquid and other materials (e.g., glass, needles). Do not pick up broken glass with gloved hands. Handle needles with extreme caution. The contaminated materials should be collected using the provided scoop.
 - Place all collected contaminant and the emesis basin in the double plastic bag. Do not seal the bags.
 - Carefully set the plastic bags aside so to prevent spillage.
 - Wash down the contaminated area with 70 percent alcohol one (1) time and use disposable paper towels to blot the area dry. Place the wet towels in the plastic double bag
 - Wash down the contaminated area three (3) times with a detergent solution followed by clean water. After each wash down, use disposable towels to blot the area dry. Place the wet towels in the plastic double bag after each wash down
 - Carefully remove all personal protective equipment

In the unlikely event that the spill control personnel punctures or lacerates the hand or fingers with a needle or broken glass, the immediate treatment is to go to the emergency room. Ensure that the emergency room staff are made aware that you have been contaminated with a chemotherapy drug.

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Ensure that all individuals who have come into contact (or are suspected of having come into contact) with the chemotherapy agents are properly and thoroughly decontaminated. This involves thorough washing of all affected areas and clothing.

Exposure and Incident Reporting

Events occurring during normal working hours must be reported to the shift supervisor or duty pharmacist, and to occupational health. In the event of exposure during an off hour, report to the emergency room.

- *Eye Contact:* An emergency eye wash station is located within the preparation area. Ask for assistance with washing. Flush eyes with copious amounts of water for at least 15 minutes and report any incident to the shift supervisor or duty pharmacist.
- *Skin Contact:* In case of skin contact with chemotherapy agents, the affected area should be washed thoroughly with soap and water.
- *Spill:* Any spill should be cleaned up immediately. All spills should be immediately reported to the Safety Office.
 - Refer to [Appendix A – Chemotherapy and Anti-Neoplastic Drug Spill Control Procedure](#) for further information.

Any workplace exposure record created in connection with hazardous drug handling shall be kept, transferred, and made available for at least 30 years and medical records shall be kept for the duration of employment plus 30 years in accordance with the OSHA Access to Employee Exposure and Medical Records Standard ([29 CFR 1910.1020](#)).

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Investigational Protocols

Investigational agents are those received via the National Cancer Institute (NCI) and can be defined as either “NON-FDA approved” or “FDA approved but for investigational procedures” as in the case of some Pediatric Oncology Groups.

Each agent will be used for one patient only. No transfer of medication will be allowed to a patient other than the intended. All chain of custody paperwork will be maintained by the Investigational Drug Officer or direct representative. This paperwork will at minimum consist of:

- ✓ Investigational Drug Accountability Record (DAR)
- ✓ Investigational Drug Nursing Administration Record
- ✓ Investigational Drug Data Record
- ✓ Local manufacturing log/paperwork
- ✓ Protocols as required by the drug manufacturer or government research body, if applicable
- ✓ Document requirements as defined in the original protocol

Records of investigational drug handling must be maintained within the pharmacy. Pharmacy staff must properly annotate all wasting of investigational protocols on the Investigational Drug Accountability Record (DAR). The DAR will include the following information:

- ✓ Name of Institution
- ✓ Protocol Number
- ✓ Drug Name, Dose Form and Strength
- ✓ Protocol Title
- ✓ Inpatient pharmacy
- ✓ Prescribing physician
- ✓ Date
- ✓ Patient's initials
- ✓ Patient's social security number (SSN)
- ✓ Dose or quantity/amount received, administered or wasted
- ✓ Balance brought forward

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- ✓ Manufacturer Lot or NCI Lot number
- ✓ Recorder's initials

Upon wasting any amount of unusable/non-dispensable agent, the chemotherapy pharmacy or technician and checking pharmacist will both countersign that it was wasted on the pharmacy's compounding log.

Each investigational protocol order will contain a label indicating that it is an investigational agent and is not intended for general use.

Surveillance of Occupational Exposure to Chemotherapy and/or Anti-Neoplastic Drugs

Personnel who are repeatedly exposed to chemotherapy agents in the course of admixture or compounding are to be included in a medical surveillance program, as determined and facilitated by the Command. Pharmacy Department Heads will ensure that program administrators are provided the names of personnel involved with these agents. At a minimum, medical surveillance for these personnel will include:

- ✓ A pre-placement physical
- ✓ Yearly medical surveillance
- ✓ Upon acute exposure, employees should have a physical examination every six months for a period of two years

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Required Training for Pharmacy Staff Handling Chemotherapy and/or Anti-Neoplastic Orders

As part of inpatient pharmacy orientation, all technicians will receive limited chemotherapy training that will allow them to safely prepare a chemotherapeutic substance in an emergency under the close supervision of a pharmacist.

Chemotherapy pharmacists and chemotherapy pharmacy technicians will receive further training prior to being assigned to work with chemotherapy. The trainee must pass a written evaluation to achieve their chemotherapy competency. Chemotherapy competencies will be reviewed annually.

Training for the chemotherapy pharmacy staff will involve:

- ✓ Aseptic technique
- ✓ Chemotherapy precautions
- ✓ Monitoring, disposal and spill procedures
- ✓ Written/verbal testing
- ✓ Technique observation
- ✓ Practical testing

Chemotherapy training records should be maintained for three years from the date on which the training occurred. Training records should include the following information:

- ✓ Dates of the training sessions
- ✓ Contents or a summary of the training sessions
- ✓ Names and qualifications of the persons conducting the training
- ✓ Names and job titles of all persons attending the training sessions

Hazardous Drug Control Officer

The Pharmacy Department Head will appoint a qualified pharmacy officer to serve as the Hazardous Drug Control Officer. The Hazardous Drug Control Officer will monitor the Hazardous Drug Program and provide advice regarding the use, disposal and other aspects of chemotherapy within the pharmacy and to other departments when requested.

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Appendix B – Acronyms

Table B-1 represents a comprehensive list of acronyms used throughout the Navy Pharmacy SOP:

Acronyms – Navy Pharmacy SOP	
Acronym	Definition
ADC	Automated Dispensing Cabinet
ADD	Attention Deficit Disorder
ADH	Ad Hoc Report Menu
ADHD	Attention Deficit Hyperactivity Disorder
ADR	Adverse Drug Reaction
AHFS	American Hospital Formulary Service
AHLTA	Armed Forces Health Longitudinal Technology Application
AOR	Area of Responsibility
APF	Annual Planning Figure
APhA	American Pharmacists Association
APV	Ambulatory Procedure Visit
ASHP	American Society of Health System Pharmacists
BAG	Budget Allocation Group
BCG	Bacillus Calmette-Guerin
BMC	Branch Medical Clinic
BO	Business Objects
BPL	Batch Print Labels
BPS	Build/Process/Submit
BSA	Body Surface Area
BSC	Biological Safety Cabinet
BUMED	Bureau of Medicine and Surgery
CAC	Common Access Card
CAIM	Customer Area Inventory Management
CAPT	Captain (O-6)
CDC	Center for Disease Control and Prevention
CDR	Commander (O-5)
CHCS	Composite Health Care System
CLAB	Compounded Lot Assignment Book
CMOP	Consolidated Mail Order Pharmacy
CMR	VA CMOP Reports Menu
CNSD	Central Nervous System Depressant
CO	Commanding Officer
COB	Close of Business
CONUS	Contiguous United States
COOP	Continuity of Operations Plan
CSA	Controlled Substances Act
CSIB	Controlled Substances Inventory Board
CSP	Compounded Sterile Products
CSTD	Closed System Drug-Transfer Device
DAR	Investigational Drug Accountability Record
DAW	Dispensed As Written
DCSS	Director of Clinical Support Services
DD	U.S. Department of Defense
DD 1155	U.S. Department of Defense Purchase Order Form
DDI	Drug-Drug Interaction

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Acronyms – Navy Pharmacy SOP	
Acronym	Definition
DEA	U.S. Drug Enforcement Administration
DEERS	Defense Eligibility Enrollment Reporting System
DHP	Defense Health Program
DHPD	Drug with High Potential for Diversion
DLA	Defense Logistics Agency
DLA-TS	Defense Logistics Agency – Troop Support
DMHRSi	Defense Medical Human Resources System-internet
DMIS	Defense Medical Information System
DMLSS	Defense Medical Logistics Standard Support
DMLSS CES	Defense Medical Logistics Standard Support Compact Edition System
DMLSS SA	Defense Medical Logistics Standard Support System Administrator
DoD	U.S. Department of Defense
DRX	Dispense Prescription
DQS	Pharmacy Site Data Quality Report
DUR	Drug Utilization Review Menu
EAS	Expense Assignment System
ED	Emergency Department
EE	Expense Element
EHR	Electronic Health Record
EMR	Expiring Medication Report
EMS	Environmental Management Systems
EO	Equal Opportunity
EPA	U.S. Environmental Protection Agency
EUD	Extra Unit Dose
EVT	Employee Verified Time
EXC	PHR Workload Exception Report
FAR	Federal Acquisition Regulation
FASTDATA	Funds Administration and Standardized Document Automation System
FDA	U.S. Food and Drug Administration
GC3	First Data Bank Therapeutic Class Code
GEN	Generation
GER	General Pharmacy Reports
GIQD	General Inquiry for DEERS
GIR	Issue Reports (General)
GTR	Transaction Reports (General)
HAM	High-Alert Medications
HAZMAT	Hazardous Materials
HEPA	High Efficiency Particulate Air
HHT	Hand Held Terminal
HIPAA	Health Insurance Portability and Accountability Act
HM1	Hospital Corpsman First Class (E-6)
HM2	Hospital Corpsman Second Class (E-5)
HM3	Hospital Corpsman Third Class (E-4)
HN	Hospitalman (E-3)
HVR	Hourly Volume Report
ID	Identification
IDC	Independent Duty Corpsmen
IDE	Investigational Device Exemption
IDU	IV Drug Utilization Review Report
IG	Inspector General
IM	Inventory Management

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Acronyms – Navy Pharmacy SOP	
Acronym	Definition
IND	Investigational New Drug Program
INR	Inventory Reports
IOM	Institute of Medicine
IRB	Institutional Review Board
ISMP	Institute of Safe Medical Practices
ISO	International Organization for Standardization
IT	Information Technology
ITCP	Information Technology Continuity Plan
IV	Intravenous
IVP	Intravenous Push
JON	Job Order Number
LASA	Look-Alike/Sound-Alike
LCDR	Lieutenant Commander (O-4)
LCPO	Leading Chief Petty Officer
LIP	Licensed Independent Practitioner
LPO	Leading Petty Officer
LT	Lieutenant (O-3)
MANMED	Manual of the Medical Department
MAP	Modify Active Prescriptions
MAR	Medication Administration Record
MEP	Medical Expense and Performance Report
MDV	Multiple Dose Vial
MEDCOM	U.S. Army Medical Command
MEPRS	Medical Expense and Performance Reporting System
MGR	MEPRS Group Report
MHS	Military Health System
MICP	Managers' Internal Control Program
MID	Medical Information Department
mL	milliliter
MM	Medication Management
MMD	Manual of the Medical Department
MMQC	Medical Materiel Quality Control
MSDS	Material Safety Data Sheet
MTF	Military Treatment Facility
MUMPS	Massachusetts General Hospital Utility Multi-Programming
NAVMED	Navy Medicine
NAVMISSA	Navy Medicine Information Systems Support Activity
NAVOSH	Navy Occupational Safety and Health
NBHC	Naval Branch Health Clinic
NCA	National Capital Area
NCI	National Cancer Institute
NCQA	National Committee for Quality Assurance
NCR	Non-Compliance Report
NDC	National Drug Code
NH	Naval Hospital
NHC	Naval Health Clinic
NIOSH	National Institute for Occupational Safety and Health
NIS	Not In Stock
NKDA	No Known Drug Allergies
NKO	Navy Knowledge Online
NMC	Naval Medical Center

Navy Pharmacy SOP: Appendix B

Acronyms – Navy Pharmacy SOP	
Acronym	Definition
NME	Navy Medicine East
NMR	Narcotic Movement Report
NMW	Navy Medicine West
NPAB	Navy Pharmacy Advisory Board
NPI	National Provider Identifier
NRR	Narcotic System Reports Menu
NSIPS	Navy Standard Integrated Personnel System
NSN	National Stock Number
O&M, DHP	Operation and Maintenance, Defense Health Program
OB	Obstetrics
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OCONUS	Outside the Contiguous United States
OCR	Outpatient Cost Reports
ODU	Outpatient Drug Utilization Review Report
OHI	Other Health Insurance
OIC	Officer in Charge
OIR	Outstanding Issue Report
OLUM	Online Users Manual
OP	Operative
OP, DHP	Other Procurement, Defense Health Program
OPNAV	Chief of Naval Operations
OPR	Outpatient Pharmacy Reports
OPTAR	Operating Target
OSHA	Occupational Safety and Health Administration
OSU	Outpatient Summary Report
OTC	Over-the-Counter
OTSG	Office of the Surgeon General, U.S. Army
P&T	Pharmacy and Therapeutics
PAR	Product Activity Report
PC	Personal Computer
PD	Position Description
PDA	Personal Digital Assistant
PDTs	Pharmacy Data Transaction Service
PEC	Department of Defense Pharmacoeconomic Center
PEM	Patient Education Monograph
PHI	Protected Health Information
PHR	Pharmacy Subsystem
PII	Personally Identifiable Information
PMI	Pharmacy Patient ID Missing Report/Processing
POC	Pharmacy Operations Center
PoS	Point of Service
PPE	Personnel Protective Equipment
PPR	Patient Profile Report
PRN	Pro re nata
PAR	Product Activity Report
Pro-DUR	Prospective Drug Utilization Review
PSP	U.S. Department of Defense Patient Safety Program
PSR	Prescriptions in Suspense Report
PSR	Print Spooled Report
PSR	Patient Safety Reporting System
PVP	Prime Vendor Pharmacy

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Acronyms – Navy Pharmacy SOP	
Acronym	Definition
QA	Quality Assurance
ROP	Reorder Point
RTS	Return to Stock
Rx	Prescription
SA	System Administrator
SDV	Single Dose Vial
SIM	Stock Issue Movement Report
SIR	Issue Reports (Specific)
SLDCADA	Standard Labor Data Collection and Distribution Application
SLEP	Shelf-Life Extension Program
SMART	Summarized Management Analysis Tool
SOP	Standard Operating Procedure
SOS	Source of Supply
SPM	Spooler Menu
SSN	Social Security Number
STARS-FL	Standard Accounting and Reporting System-Field Level
STAT	Statim
STR	Transaction Reports (Specific)
SVR	Supply Voucher Report
TFL	TRICARE for Life
TFW	Test Drugs for Warnings
TJC	The Joint Commission
TMA	TRICARE Management Activity
TMO	TMOP Report Menu
TMOP	TRICARE Mail Order Pharmacy
TOW	Transfer of Ward
TPN	Total Parenteral Nutrition
UDU	Unit Dose Drug Utilization Review Report
UL	Underwriters Laboratory
UNR	PDTS Unavailability Report
UPN	Universal Product Number
USNH	United States Naval Hospital
USP	United States Pharmacopeia
VA	U.S. Department of Veterans Affairs
VIC	Veterans Identification Card
VSR	Volume Summary Report
WAM	Work Assignment Module
WAWF	Wide Area Workflow

Table B-1: Acronyms

Navy Pharmacy SOP: Appendix C

Appendix C – Glossary

Table C-1 represents a comprehensive glossary of terms used throughout the Navy Pharmacy SOP:

Glossary – Navy Pharmacy SOP	
Term	Definition
2359 Patient	Classification of a patient as 2359 denotes that the patient's length of stay and treatment will total less than 24 hours.
29 CFR 1910.1020	OSHA Access to Employee Exposure and Medical Records Standard which pertains to employers in the industry, maritime and construction fields and which provides their employees and their employees' designated representatives with a right of access to relevant exposure and medical records.
ActiveSync	A mobile data synchronization tool utilized to transmit PDA-built pharmacy orders to a customer's desktop for execution in DMLSS.
ADC Super-User	Pharmacy staff member who has the primary rights to the ADC. The super-user is often the senior pharmacy technician.
Ad Hoc Report Menu (ADH)	CHCS report that allows users to create ad hoc reports using data in any of the system files within the FileMan database management system user interface.
Armed Forces Health Longitudinal Technology Application (AHLTA)	Electronic health record system employed by MHS providers.
Anti-Neoplastic Order	Medications used to inhibit the development and spread of neoplastic cells.
Ambulatory Procedure Visit (APV)	Classification of a patient as APV denotes that the patient's length of stay and treatment will total less than 24 hours.
Aseptic Technique	Procedure performed under sterile conditions. Examples include the laboratory procedures required for the preparation of chemotherapy and anti-neoplastic orders.
AudioCare	Automated refill request system that allows patients to submit refill requests to batch refill pharmacies for future pick-up.
Automated Dispensing Cabinet (ADC)	Computerized drug storage cabinet, such as Pyxis or Omnicell, which allows medication to be stored and dispensed near the point of care.
Batch Print Labels (BPL)	Function in CHCS which enables pharmacy staff to print labels for all refill requests awaiting filling.
Batch Refill Dispensing Pharmacy	A pharmacy that dispenses batch refills. This pharmacy may be either an Independent Batch Refill Pharmacy or use a Centralized Batch Refill Pharmacy for batch refill processing and filling.
Batch Refill Operations	Batch refill operations include the processing and filling of refill prescriptions that patients have submitted to the pharmacy remotely (i.e. through the use of the automated refill request system, AudioCare) for future pick-up.
Best Pharm Report	A DLA tool used to identify best priced pharmacy items.
Beyond-Use Date	The date beyond which a medication is no longer safe for use. This day may not exceed the manufacturer's original expiration date, or one year from the date of repackaging, whichever is less.
BUMEDINST 6280.1B	BUMED Instruction on Management of Regulated Medical Waste. Pharmacy staff should refer to this instruction for standards for management of regulated medical waste.
BUMEDINST 6320.16	BUMED Instruction on Informed Consent for Medical and Dental Treatment. Pharmacy staff at CONUS MTFs should refer to this instruction when determining if a patient is of an appropriate age to pick-up a prescription.
BUMEDINST 6320.66E Change Transmittal 2	BUMED Instruction on Credentials Review and Privileging Program. Pharmacy staff should refer to this instruction for a credentials checklist for privileged practitioners and non-privileged Navy health care providers and nurses.

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Glossary – Navy Pharmacy SOP	
Term	Definition
BUMEDINST 6570.3	BUMED Instruction on Hazardous Drugs and Safety Health Plan. Pharmacy staff should refer to this instruction for policies and guidelines regarding occupational exposures to hazardous drugs.
BUMEDINST 6710.62B	BUMED Instruction on the Navy Medicine Shelf Life Extension Program. Pharmacy staff should refer to this instruction for policies and guidelines on the management, disposal and relabeling of dated pharmaceuticals.
BUMEDINST 6710.69	BUMED Instruction on the Use of Investigational Agents in Humans. Pharmacy staff should refer to this instruction if participating in the FDA Investigational New Drug (IND) Program.
Business Objects	A SAP product which allows web-based business intelligence reporting. The Business Objects function in DMLSS allows pharmacy staff to run custom reports that aid in managing the DMLSS catalog.
Cart List	CHCS generated list of medications stocked in the unit dose cart for administration to inpatients at the time the cart list was printed.
Centralized Batch Refill Pharmacies	Commands that centralize refill operations at a single facility. A Centralized Batch Refill Pharmacy is designed to process and fill refill prescriptions for one or more pharmacies within their Command, and deliver these refill prescriptions to the designated batch refill dispensing pharmacy locations for dispensing to patients.
CHCS Downtime Log	Pharmacy log used to record all instances of CHCS downtime in the pharmacy.
Class II Type B Biological Safety Cabinet	An enclosed, ventilated laboratory space located in the pharmacy clean room and used by pharmacy staff in the preparation of chemotherapy agents.
Clinic Issue Function of CHCS	Used to document ward requests for medication that is external to their normal stocking requirements, and pharmacy filling of that request. Pharmacy staff use the "Clinic Issue" function to document that the order was requested and filled and thus receive workload credit.
Clinical Warning	A warning which will appear in CHCS if the drug warning check reveals the need for further verification. Review of clinical warnings must include a drug warning review and a review of allergy, duplicate medication and drug warning class.
Closed System Drug-Transfer Device (CSTD)	A drug transfer device that mechanically prohibits the transfer of environmental contaminants into the system and the escape of hazardous drug or vapor concentrations outside the system.
Cold Chain	A temperature-controlled supply chain, used for medications requiring refrigeration.
Cold Chain Items	Medications requiring refrigeration, and which are transported via cold chain (a temperature-controlled supply chain).
Command	Unit of the United States Navy under a Commander.
Common Access Card (CAC)	A smart card issued by the U.S. Department of Defense to personnel who have been authorized access to government facilities, resources and/or benefits.
Composite Health Care System (CHCS)	System utilized by pharmacy staff to review and process inpatient orders and outpatient prescriptions, and to access patient information.
Consolidated Mail Order Pharmacy (CMOP)	A mail order pharmacy option available to veterans, through which refill prescriptions are delivered directly to their homes.
Consolidation Therapy	Treatment given after cancer has disappeared following initial therapy. Used to kill cancer cells that remain in the body.
Continuity of Operations Plan (COOP)	Plan which outlines how the essential components of Navy Pharmacy operations will function during an emergency situation. Each Pharmacy Department Head should ensure that their COOP is aligned with, and incorporated into, the Command COOP.

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Glossary – Navy Pharmacy SOP	
Term	Definition
Controlled Substances	Per the Comprehensive Drug Abuse and Prevention and Control Act of 1970, controlled substances are medications which have been classified into five schedules and whose distribution, possession, and use is regulated by the federal government.
Controlled Substances Inventory Board (CSIB)	Board consisting of at least 3 members that conducts quarterly, or more frequent, inventories of controlled substances, ensures physical security of pharmacy spaces, and monitors access to controlled substances.
Crash Cart Tray	A portable tray that is stored in the ward, so as to be readily accessible to staff, and which contains medications for use in emergency patient care.
Critical Duty	A component/role within the respective SOP Section comprised of processes that must be performed in order for the Critical Duty to be considered fully complete. For example, Patient Check-In is a Critical Duty within the Outpatient Section.
Current Medications	In the National Patient Safety Goals (Hospital Accreditation Program) effective January 2013, the Joint Commission acknowledges that it can be difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the element of performance
Cytotoxic Agent Control Officer	A qualified pharmacy officer, appointed by the Pharmacy Department Head, who will monitor the Cytotoxic Agent Program and provide advice regarding the use, disposal and other aspects of chemotherapy within the pharmacy, as well as to other departments when required.
Cytotoxic Agent Program	All cytotoxic protocols in use within the pharmacy. These protocols are monitored by the Cytotoxic Agent Control Officer.
DD 250	U.S. Department of Defense Material Inspection and Receiving Report used to receipt pharmacy supply orders.
DD 1155	U.S. Department of Defense Purchase Order Form used when ordering supplies and services. Required for the execution of PVP Credit Orders and Off-Line Non-Submit Schedule-II pharmaceutical orders.
DD 1289	U.S. Department of Defense prescription form used by authorized prescribers.
DEA Report (DEA)	CHCS report that allows the user to print prescription data for all controlled substance prescriptions filled for a specified date range.
Defense Enrollment Eligibility Reporting System (DEERS)	Computerized database of eligible TRICARE beneficiaries. Pharmacy staff use this database to verify a patient's eligibility to receive care.
Division Officer	Navy Officer in charge of a division.
Defense Medical Human Resources System-internet (DMHRSi)	A web-based tool that captures, tracks, and accounts for all human resources.
Disposal of Controlled Substances (Title 21 § 1307.21)	Title 21 Section 1307.21 of the Controlled Substances Act pertains to "procedures for the disposing of controlled substances," specifically the protocol for requesting assistance from the Special Agent in Charge of the Administration when disposing of a controlled substance.
DoD Patient Safety Program (PSP)	A comprehensive, centralized program with the goal of establishing a culture of patient safety and quality within the MHS.
Downtime	The state in which pharmacy automation systems are unavailable for use. This may be due either to power outage or system malfunctioning.
DPRX	Function in CHCS that displays the patient's PDTs profile.
Draft Department of Defense (DoD) Compounded Pharmaceuticals Recipe Book	Resource which provides compounding guidelines and pre-packing instructions for all compounded and prepackaged pharmaceuticals.
Drug Classes	The Controlled Substances Act (CSA) divides drugs into different classes, each of which has distinguishing properties and applicable regulations based on drug effects and potential for abuse.

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Glossary – Navy Pharmacy SOP	
Term	Definition
Drugs with High Potential for Diversion (DHPDs)	Medications identified by the Command as having abuse potential and requiring security measures similar to those for controlled substances.
Drug Utilization Review Menu (DUR)	CHCS report that allows CHCS users to print reports on the utilization (dispensing) of IV, Outpatient or Unit Dose medications. This report can be accessed with the menu path Pharmacy System Menu → PRM → DUR.
Essentris	System utilized by MTF inpatient providers to input patient orders and transfer them to the pharmacy for filling.
Essentris Status Board	Component of the Essentris system that indicates the status of patient orders, including the status of medication reconciliation and instances in which a pending order is awaiting provider or ward staff clarification.
Expiration date	Date past which a medication is no longer safe for patient use. Expired medications should be disposed of in accordance with the processes outlined in the Navy Pharmacy SOP.
The Federal Managers' Financial Integrity Act of 1982	This Act requires all managers to establish effective internal controls and report on their effectiveness. Navy Medicine complies with this Act through execution of the Managers' Internal Control Program (MICP).
The Food and Drug Administration – Enforcement Reports	A list of all drug recalls, classified according to the level of hazard which precipitated the recall. These reports are available on the FDA website.
First Data Bank	Publisher of the pharmaceutical drug information that is printed from CHCS and provided as a patient education monograph (PEM) with each prescription dispensed.
Formulary	List of medications currently available for dispensing at military treatment facilities, as determined by the U.S. Department of Defense. A Command's formulary may be modified by the Pharmacy & Therapeutics Committee, as appropriate, to meet scope of services and population need.
Funds Administration and Standardized Document Automation System (FASTDATA)	FASTDATA is a web-based application used to track spending for the MTFs, the branch clinics, and their respective departments.
GC3	First Data Bank Therapeutic Class Codes, which classify medications by organ system, pharmacological class and specific therapeutic class, respectively.
General Inquiry for DEERS (GIQD)	Web-based system for checking patient eligibility for pharmaceutical benefits.
Generic Medication Name	Medication name that refers to the chemical composition of the drug, rather than the brand name under which it is advertised. Generic medications are comparable to their brand name counterparts in dosage, intended use, route of administration and effects.
General Pharmacy Reports (GER)	CHCS menu that allows CHCS users to display or print data from all pharmacy areas.
Health Insurance and Accountability Act (HIPAA)	Enacted in 1996 to provide federal protections for personal health information and ensure the confidentiality and integrity of electronic protected health information.
High-Alert Medications (HAM)	Medications that have been identified as being involved in a high percentage of errors and which carry a more significant risk of causing serious patient harm when used in error.
Hourly Volume Report (HVR)	CHCS report that allows you to request a report within a specified date range. The report is broken down by hourly volumes for processing prescriptions.
Independent Batch Refill Pharmacies	Pharmacies that individually complete the full scope of batch refill operations. These pharmacies differ from Centralized Batch Refill Pharmacies in that the refill prescriptions are processed, filled and dispensed at the same pharmacy location.

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Term	Definition
Induction Therapy	Initial therapy to reduce a cancer. Typically followed by other treatments to eliminate cancer that remains.
Investigational Drug Accountability Record (DAR)	Record of receipt and dispensing of investigational agents, as required by the National Cancer Institute (NCI) and U.S. Food and Drug Administration (FDA).
Investigational Drug Data Record	Document which must be completed for all investigational drugs intended for administration to hospital inpatients. The record includes information on the administration of the protocol, as well as known toxicities and interactions.
Investigational Drug Nursing Administration Record	Record of administration of investigational medications to hospital inpatients by nursing staff.
Investigational Drug Officer	Hospital staff member in charge of maintaining all chain of custody paperwork relating to the use of investigational drugs and their administration to hospital inpatients.
Investigational New Drug (IND) Program	U.S. Food and Drug Administration (FDA) program by which a pharmaceutical company receives permission to transport investigational drugs across state lines, prior to receipt of an approved marketing application.
IV Drug Utilization Review Report (IDU)	CHCS report that allows CHCS users to print reports on the utilization (dispensing) of IV medications. This report can be accessed with the menu path Pharmacy System Menu → PRM → DUR → IDU.
Joint Commission	See “The Joint Commission.”
Joint Commission Medication Management Standards	Provide the basis of the Joint Commission's evaluation process in determining whether a health care organization is available for accreditation and certification.
Joint Commission National Patient Safety Goals	Established by the Joint Commission to ensure patient safety and assist accredited organizations address areas of specific concern with regards to patient safety.
L4 Template	PDTS Standard Report Template for Business Objects users trained prior to April 2005.
Licensed Independent Practitioner (LIP)	Individuals permitted by law and the health care organization in which they work to provide patient care without supervision, within the scope of services they are licensed to provide (e.g. Registered Nurse, Physician).
Look-Alike/Sound-Alike Medications (LASA)	Medications with look-alike or sound-alike names which require special safeguards to prevent medication errors.
Lot Number Generation	Each medication is assigned an appropriate lot number. When generating lot numbers, pharmacy staff must use the following equation: [two digit of year's last two digits] + [Julian date] + [# of unit dose product for that day] + [n=narc/control, c=outpatient compound, u=inpatient unit dose and i=IV batches]
Maintenance Therapy	Treatment given following induction therapy, to prevent cancer from returning after it has disappeared.
Mandatory National Contract	DLA-published list of federally contracted pharmaceutical items available for purchase at pre-established rates through the prime vendor.
The Manual of the Medical Department (MANMED) Chapter 21: Pharmacy Operation and Drug Control	Chapter 21 of the Manual of the Medical Department of the United States Navy details the BUMED policy regarding Pharmacy Operation and Drug Control. All procedures in this Navy Pharmacy SOP are in accordance with the policies established in Chapter 21.
Material Safety Data Sheet (MSDS)	Provides pharmacy staff with the procedures necessary to appropriately handle hazardous chemicals.
Medical Expense and Performance Reporting System (MEPRS)	Standard cost accounting system for the Military Health System (MHS). This system contains Tri-Service financial, personnel, and workload data from military treatment facilities worldwide.
Medication Administration Record (MAR)	Record of medications administered to a patient at an inpatient facility. Pharmacy staff shall consult the MAR to determine the medications needed to stock the unit dose cart or other patient-specific bins.

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Term	Definition
MEPRS Group Report	CHCS menu option that prints the MEPRS Group report for user-specified "groups" and date range.
Must	The use of the word "must" shall be used when stating mandatory requirements; "must" is used only to describe unavoidable situations. "Must" is synonymous with "obligated to."
Must Contact Pharmacist List	Denotes drugs and drug classes that require pharmacist review of the provider's order within 24 hours of receipt.
Narcotic System Reports Menu (NRR)	CHCS menu that provides options for generating reports specific to the Narcotic System, tracking such information as medications approaching expiration, narcotics, issues, inventory, outstanding issues, supply vouchers, and transaction statistics.
National Committee for Quality Assurance (NCQA)	Not-for-profit organization which provides accreditation to health plans.
National Patient Safety Goals	Established by the Joint Commission, to help accredited organizations address patient safety issues. These goals are reviewed and republished annually.
NAVMED 6710/1	Narcotic and Controlled Drug Account Record which is used to account for all controlled substances stored in the pharmacy.
NAVMED 6710/4	Narcotic and Controlled Drug Inventory which is issued in conjunction with the NAVMED 6710/1 and is used to document pharmacy inventory of controlled substances.
NAVMED 6710/6	Poly Prescription Form which enables pharmacy staff to simultaneously prescribe multiple prescriptions to the same patient.
NAVMED POLICY 10-005	The Navy Pharmacy Assessment of Barriers to Learning Policy establishes the minimum requirements pharmacy staff should use when defining barriers for learning.
Navy Occupational Safety and Health (NAVOSH) Program	NAVOSH provides safety assistance and advice on safety and occupational health to enhance the operational capability of the Navy and Marine Corps.
Navy Occupational Safety and Health (NAVOSH) Program Manual (OPNAVINST 5100.23E)	OPNAVINST 5100.23E is a complete revision of OPNAVINST 51000.23D. It affirms the NAVOSH Program for all Navy personnel and implements the following DOD instructions: DOD 6055.1, DOD 6055.5, DOD 6055.7, and DOD 6055.11.
Navy Standard Integrated Personnel System (NSIPS)	A web-based tool for electronic submission and approval of employee leave time.
Non-Compliance Report (NCR)	CHCS report showing noncompliant information for all patients who fail to pick up their prescriptions within a specified time period, as defined by the MTF.
Non-Formulary Medication	Medication not listed on the Command's formulary, and which is therefore not available for dispensing. Non-formulary prescription requests must receive pharmacist approval prior to being filled.
NOW Orders	Orders that are prioritized after "STAT" orders have been processed. These orders must be filling within 60 minutes of pharmacy receipt of the order, provided that safety and circumstances allow.
OBRA 90	Omnibus Budget Reconciliation Act of 1990 gave states the ability to create Pharmacy and Therapeutics Committees and required that Medicare Supplement policies be standardized.
OTSG/MEDCOM POLICY Memo 10-076	MEDCOM Policy on Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy involving Psychotropic Medications and Central Nervous System Depressants.
Outpatient Cost Reports (OCR)	CHCS menu that contains prescription fill cost and drug unit cost reports.
Outpatient Drug Utilization Review Report (ODU)	CHCS report that allows CHCS users to print reports on the utilization (dispensing) of outpatient medications. This report can be accessed with the menu path Pharmacy System Menu → PRM → DUR → ODU.

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Glossary – Navy Pharmacy SOP	
Term	Definition
Officer of the Day	Rotating duty among commissioned officers, tasked with security and law enforcement throughout the duty period.
Omnicell	Automated Dispensing Cabinet (ADC) system, allows medication to be stored and dispensed near the point of care.
Online Users Manual (OLUM)	The CHCS Online Users Manual provides user instructions for MailMan, the CHCS basic system. CHCS users can access the index through the menu path OLUM → IND → MMG, or access the table of contents through the menu path OLUM → TOC → MMG.
Operation and Maintenance, Defense Health Program (O&M, DHP)	Congressional appropriation that provides medical and dental services to active forces, mobilized Reserve Components, and their family members in support of Operation Enduring Freedom.
OPNAV Instruction 5354.1F	Chief of Naval Operations policy on Navy Equal Opportunity. This policy provides guidance on equal opportunity, including prevention of unlawful discrimination and sexual harassment.
Operating Target (OPTAR)	The OPTAR is issued directly from the operating budget and provides the funds allocation to execute.
Other Procurement, Defense Health Program (OP, DHP)	Congressional appropriation that provides funds for the procurement of major equipment and weapons other than ships, aircraft, missiles and torpedoes.
Outpatient Summary Report (OSU)	CHCS menu option that provides a summary of all prescriptions that were filled and refilled for a specified date range.
Override Report	Daily report that lists all medications that have been pulled from the Automated Dispensing Cabinet via override.
Over-the-Counter Handout (OTC) Program	Program by which over-the-counter (OTC) drugs are dispensed from the pharmacy in conjunction with a health care screener.
Patient Profile Report (PPR)	CHCS menu option allows you to display or print a report showing patient prescription information (profiles) for a selected patient or group of patients.
PDTS Unavailability Report (UNR)	CHCS report that includes any prescriptions that generated an unavailable label within the Pharmacy.
PEC/POC Reports	The Pharmacoeconomic Center (PEC)/Pharmacy Operations Center (POC) utilizes PDTS Report Templates to monitor Navy Pharmacy workflow data. Pharmacy staff with valid access to the PDTS Business Objects may download the PDTS Report Templates from the Corporate Documents folder of Business Objects.
Pediatric Oncology Group	Cooperative group involved in clinical trials in pediatric oncology.
Pediatric Patients	Patients 12 years of age and younger.
Personally Identifiable Information (PII)	Information that can be used to uniquely identify or contact an individual.
Personnel Protective Equipment (PPE)	Protective clothing, to include a sterile gown, head gear, shoe covers, gloves and face mask (all disposable), intended to protect pharmacy staff when handling hazardous materials or sterile products.
Pharmacist	Pharmacy staff shall refer to their Command PD's, until such time as the Navy Pharmacy PD's have been standardized and included in the Navy Pharmacy SOP.
Pharmacy & Therapeutics Committee	A committee of healthcare professionals who advise the Command on issues pertaining to medication use including, but not limited to, the contents of the Must Contact Pharmacist List and Command Formulary.
Pharmacy Data Transaction Service (PDTS)	Centralized data repository that allows the U.S. DoD to build a common patient medication profile for all MHS beneficiaries and allows providers to review a patient's complete medication history.
Pharmacy Department Head	Pharmacy staff shall refer to their Command PD's, until such time as the Navy Pharmacy PD's have been standardized and included in the Navy Pharmacy SOP.

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Glossary – Navy Pharmacy SOP	
Term	Definition
Pharmacy Patient ID Missing Report/Processing (PMI)	CHCS option that allows the user to generate a report by date range of all patients who received prescriptions, but do not currently have a patient ID in the Patient file.
Pharmacy Site Data Quality Report (DQS)	CHCS report which should be generated to validate the Performing MEPRS codes for Pharmacy.
Pharmacy Staff	Pharmacy staff shall refer to their Command PD's, until such time as the Navy Pharmacy PD's have been standardized and included in the Navy Pharmacy SOP.
Pharmacy System Manager	Pharmacy staff shall refer to their Command PD's, until such time as the Navy Pharmacy PD's have been standardized and included in the Navy Pharmacy SOP.
Pharmacy Technician	Pharmacy staff shall refer to their Command PD's, until such time as the Navy Pharmacy PD's have been standardized and included in the Navy Pharmacy SOP.
PHR Workload Exception Report (EXC)	This menu option reports workload associated with invalid and/or inactive MEPRS Codes/DMIS IDs.
Point of Service (PoS)	The specific location and payment method through which a patient receives their medication. The three applicable points of service in the Navy Pharmacy Community are MTF, Retail and Mail Order.
Poison Prevention Packaging Act of 1970	An Act developed in conjunction with the Consumer Products Safety Commission, which establishes packaging requirements for certain hazardous household goods, to minimize the possibility of accidental poisoning of minors in homes where these substances are present.
Prescriptions in Suspense Report (PSR)	Function within CHCS that allows pharmacy staff to identify pending refill requests that have transferred into CHCS from AudioCare.
Print Spooled Report (PSR)	CHCS menu option that creates a report of all prescriptions that would batch if a user chose to batch all.
The Privacy Act of 1974	Enacted in 1974, the Privacy Act protects records that contain personal identifiers such as a name, social security number, or other identifying numbers or symbols.
Process	A specific set of actions required to complete each responsibility within the Navy Pharmacy SOP.
Product Activity Report (PAR)	CHCS report that displays the quantities of drugs dispensed by the outpatient and inpatient pharmacies over a time frame specified by the user.
Provider and Pharmacist Training on Mefloquine Usage for Malaria Prophylaxis	BUMED training that describes Department of Defense requirements for prescribing and dispensing mefloquine.
PRN Orders	Orders that are written to be "dosed when needed."
Protected Health Information (PHI)	Information regarding a patient's health status or health care that can be traced to a specific individual.
Pyxis	Automated Dispensing Cabinet (ADC) system, allows medication to be stored and dispensed near the point of care.
PyxisConnect	Digital imaging device used to document order edits in wards without Essentris availability.
QFlow	Queuing system used to regulate the flow of beneficiaries in the pharmacy, to include ticket prioritization.
Q-Matic	Queuing system used to regulate the flow of beneficiaries in the pharmacy, to include ticket prioritization.
Quick Order Template	CHCS templates for commonly performed procedures and treatment regimens. These templates mirror physician order sheets and allow pharmacy staff to quickly enter an order into CHCS by selecting the appropriate medication, rather than manually entering the medication and dose.
Refill Report	Report run in the ADC to identify medications that have depleted below minimum stock levels and need to be refilled.

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Term	Definition
Remote Site	Navy Pharmacy site without a pharmacist, and at which a pharmacy technician utilizes telepharmacy technology to complete pharmacist verification and consultation procedures related to Outpatient prescription processing and dispensing.
Replenishment Exception	An error posted to the DMLSS Customer In Box indicating a specific item was not generated and an order is not pending.
Re-Queue Posting Errors	Function within CHCS that allows pharmacy staff to identify refill requests within the AudioCare system that did not originally post to CHCS and must therefore be manually transferred into CHCS.
Return to Stock (RTS)	Function within CHCS that allows pharmacy staff to annotate medications that have been returned to stock.
RxOrder	Prescription label technology, used during CHCS downtime to prepare and print prescription labels.
Safe Use of Automated Dispensing Cabinet Guidelines	Produced by the American Society of Health Systems Pharmacists to provide guidelines around the safe use of automated medication dispensing devices in the health care setting.
Schedule-I Drugs	As classified by the Controlled Substances Act, Schedule-I medications do not have any accepted medical uses and have a high potential for abuse. No prescriptions may be written for Schedule-I medications.
Schedule-II Drugs	As classified by the Controlled Substances Act, Schedule-II medications have restricted, accepted medical uses and have a high potential for abuse. No refill prescriptions may be provided for Schedule-II medications.
Schedule-III Drugs	As classified by the Controlled Substances Act, Schedule-III medications have less potential for abuse than Schedule-I or II medications, and are accepted for medical usage. Prescriptions for Schedule-III medications must be filled within 6 months of the date originally written and may be refilled, if authorized by the prescriber, up to 5 times within 6 months of the date originally written.
Schedule-IV Drugs	As classified by the Controlled Substances Act, Schedule-IV medications have less potential for abuse than Schedule-I-III medications, and are accepted for medical usage. Prescriptions for Schedule-IV medications must be filled within 6 months of the date originally written and may be refilled, if authorized by the prescriber, up to 5 times within 6 months of the date originally written.
Schedule-V Drugs	As classified by the Controlled Substances Act, Schedule-V medications have less potential for abuse than Schedule-I-IV medications, and are accepted for medical usage. Prescriptions for Schedule-V medications must be filled within 6 months of the date originally written and may be refilled, if authorized by the prescriber, up to 5 times within 6 months of the date originally written.
ScriptPro	Telepharmacy technology system that may also be employed in outpatient pharmacy processes.
Section	Distinct operational function of the Navy Pharmacy workflow, The Navy Pharmacy SOP is comprised of eight (8) Sections: Inpatient, Outpatient, Telepharmacy, Batch Refill, Supply, Administrative, Compounding and Controlled Substances, which combined make up the entire scope of operations of Navy Pharmacy, as represented in the Navy Pharmacy SOP.
Shall	The word “shall” is used to indicate mandatory future requirements strictly to be followed in order to conform to the standard and from which no deviation is permitted. “Shall” is synonymous with “expect to” or “plan to” in order to meet a future obligation.
Shelf Count Logic	The preferred method for preparing and conducting a pharmacy supply inventory.
Should	The word “should” is used to indicate that among several possibilities one is recommended as a best practice, without mentioning or excluding others; or that a certain course of action is preferred but not necessarily required. “Should” is synonymous with “recommended that.”

Navy Pharmacy SOP: Appendix C

Glossary – Navy Pharmacy SOP	
Term	Definition
SIG	A prescription's SIG indicates the directions for use and should be found on every prescription label.
Spooler Menu (SPM)	CHCS menu that contains options for printing and deleting spooled reports.
STAT Orders	Orders that require immediate processing. Pharmacy staff prioritize "STAT" orders before all others, and begin processing immediately.
Standard Labor Data Collection and Distribution Application (SLDCADA)	A web-based timekeeping tool that tracks employee (military, civilian and contractor) hours against their job order numbers and type hour codes for financial and pay purposes.
Stock Issue Movement Report (SIM)	CHCS report that provides information on bulk/clinic issues of medication to wards/clinics.
Summarized Management Analysis Tool (SMART)	SMART is a web-based analytical application into which Navy Medicine uploads spending plan information, to assist in measurement of obligation rates and analysis of execution rates.
Super-User	See "ADC Super-User."
Support Site	Navy Pharmacy site with a pharmacist, and at which a pharmacist utilizes telepharmacy technology to assist a Remote Site in completing pharmacist verification and consultation procedures related to Outpatient prescription processing and dispensing.
System Administrator (SA)	Pharmacy staff member who has been designated as the SA and who is responsible for the assignment of roles and privileges for the pharmacy site's DMLSS program.
Task	Requirements to complete a Process within the Navy Pharmacy SOP.
Telepharmacy Terminal	Component of the ScriptPro Telepharmacy technology with which pharmacy staff interact, when performing telepharmacy operations in the Navy Pharmacy environment.
The Joint Commission	A non-profit organization that accredits health care organizations, including Military Treatment Facilities.
Title 21 § 1307.21	See "Disposal of Controlled Substances (Title 21 § 1307.21)."
Trade Medication Name	Brand name for a medication and the name under which the medication is marketed.
TRICARE	United States Department of Defense Military Health System health care program that provides civilian health benefits for military personnel, military retirees and their dependents.
TRICARE for Life	TRICARE for Life offers health benefits secondary to Medicare. All beneficiaries who have both Medicare Parts A and B are eligible to receive TRICARE for Life.
TRICARE Mail Order Pharmacy (TMOP)	TRICARE Pharmacy Home Delivery, a benefit provided to eligible TRICARE beneficiaries, in partnership with Express Scripts.
Unit Dose	Single dose of medication, often prepackaged into individual packets and administered by ward staff to hospital inpatients at appropriate intervals, as prescribed by the provider.
Unit Dose Cart	Unit dose medication not stocked in the ADC is stocked in the unit dose cart, for administration to patients by ward staff. These carts are kept on the ward and replenished by the inpatient pharmacy, as appropriate.
Unit Dose Drug Utilization Review Report (UDU)	CHCS report that allows CHCS users to print reports on the utilization (dispensing) of unit dose medications. This report can be accessed with the menu path Pharmacy System Menu → PRM → DUR → UDU.
USP 795 and 797 Standards	United States Pharmacopeia (USP) National Formulary, chapters 795 and 797, refer to "Pharmaceutical Compounding – Non-Sterile Preparations" and "Pharmaceutical Compounding - Sterile Preparations" (respectively) and describe the guidelines, procedures and compliance requirements for compounding non-sterile and sterile preparations.

Navy Pharmacy SOP: Appendix C

Glossary – Navy Pharmacy SOP	
Term	Definition
VA CMOP Reports Menu	CHCS menu option that assists with the management of the VA CMOP interface.
Volume Summary Report (VSR)	CHCS menu option that provides statistical information pertaining to actions relating to prescription processing.
Ward	Hospital unit that houses inpatients throughout their hospital stay.
Ward staff	Nursing staff assigned to the hospital ward that care for inpatients throughout their hospital stay, to include the administration of prescribed medications at appropriate intervals.
Webi Template	PDTS Standard Report Template for Business Objects users trained after April 2005.
Wide Area Workflow (WAWF)	A web-based tool for electronic submission and processing of receiving reports and invoices.
Will	The use of the word “will” is only used in statements of fact. “Will” is synonymous with “mandated to.”

Table C-1: Glossary Terms

Navy Pharmacy SOP: Appendix D

Appendix D – Additional References

In addition to, and in coordination with the Navy Pharmacy SOP, Navy Pharmacy operates under established standards of practice and guidelines. Table D-1 represents a list of these additional references, including those cited within this SOP.

Additional References – Navy Pharmacy SOP	
Term	Link
American Pharmacists Association (APhA)	http://www.pharmacist.com
American Society of Health-Systems Pharmacists (ASHP)	http://www.ashp.org
ASHP Outsourcing Sterile Products Preparation: Contractor Assessment Tool	http://www.ashpfoundation.org/SterileProductsTool
Defense Medical Human Resources System – internet (DMHRSi)	https://dmhrsi.csd.disa.mil/
Department of Defense	http://www.defense.gov
Department of Defense Pharmaceutical and Therapeutics (P&T) Committee	http://pec.ha.osd.mil/PT_min_charter.php?submenuheader=5
The Department of Defense Pharmacoeconomic Center (PEC)	http://pec.ha.osd.mil
Department of Defense Pharmacoeconomic Center's (PEC) Pharmacy Disaster Plan	http://pec.ha.osd.mil/pdts/pdts_pdp.php?submenuheader=2
Department of the Navy	http://www.navy.mil
Disposal of Controlled Substances (Title 21 § 1307.21)	http://www.deadiversion.usdoj.gov/21cfr/cfr/1307/1307_21.htm
Draft Department of Defense (DoD) Compounding Pharmaceuticals Recipe Book	<i>This document can be accessed on the Navy Pharmacy NKO Page - https://wwwa.nko.navy.mil/portal/navymedicine/fip/home/navypharmacysop?paf_default_view=true</i>
Drug Enforcement Agency (DEA)	http://www.justice.gov/dea
DEA Office of Diversion Control	http://www.deadiversion.usdoj.gov/
Environmental Protection Agency (EPA)	http://www.epa.gov
The Federal Managers' Financial Integrity Act of 1982	http://www.whitehouse.gov/omb/financial_fmfi1982
The Food and Drug Administration (FDA)	http://www.fda.gov
The Food and Drug Administration – Enforcement Reports	http://www.fda.gov/Safety/Recalls/EnforcementReports/default.htm
The Health Insurance Portability and Accountability Act of 1996 (HIPAA)	http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html
General Inquiry for DEERS (GIQD)	https://www.dmdc.osd.mil/appj/giqd/login.jsp
Informed Consent for Medical and Dental Treatment Instruction (BUMEDINST 6320.16)	http://www.med.navy.mil/directives/ExternalDirectives/6320.16.pdf
Institute of Safe Medical Practices	http://www.ismp.org
The Joint Commission Standards	<i>Consult Pharmacy Department Head for latest guidelines</i>
The Manual of the Medical Department Chapter 21: Pharmacy Operation and Drug Control	http://www.med.navy.mil/directives/Documents/NAV MED%20P-117%20(MANMED)/MANMED%20CHANGE%20133.pdf
Military Vaccine Agency	http://www.vaccines.mil/QuickReference
National Institute for Occupational Safety and Health (NIOSH)	http://www.cdc.gov/niosh
Navy Bureau of Medicine and Surgery	http://www.med.navy.mil

Navy Pharmacy SOP: Appendix D

Navy Equal Opportunity (EO) Policy (OPNAV Instruction 5354.1F)	http://www.cnic.navy.mil/navycni/groups/public/@pub/@hq/documents/document/cnicc_068590.pdf
Navy Medicine/BUMED Directives (Main Site)	http://www.med.navy.mil/directives/Pages/default.aspx
Navy Medicine Information System Support Activity (NAVMISSA)	http://www.med.navy.mil/SITES/NAVMISSA/Pages/NAVMISSAHome.aspx
Navy Occupational Safety and Health (NAVOSH) Program Manual (OPNAVINST 5100.23E)	http://www.safetycenter.navy.mil/
Navy Pharmacy Assessment of Barriers to Learning Policy	http://www.med.navy.mil/policy-guidance/Documents/NAVMED%20POLICY%2010_005.pdf.PDF
Navy Pharmacy Community SharePoint Page	https://es.med.navy.mil/bumed/m3/m35/M35HO/m3/CIO/ClinicalAdvisoryBoards/NPAB/Rx/default.aspx
Navy Pharmacy NKO Page	https://wwwa.nko.navy.mil/portal/navymedicine/fip/home/navypharmacysop?paf_default_view=true
"Navy Pharmacy Resources for Managers"	<i>This document can be accessed on the Navy Pharmacy NKO Page -</i> https://wwwa.nko.navy.mil/portal/navymedicine/fip/home/navypharmacysop?paf_default_view=true
Navy Standard Integrated Personnel System	http://www.public.navy.mil/bupers-npc/organization/npc/IM/corporatessystems/Pages/nsips.aspx
Provider and Pharmacist Training on Mefloquine Usage for Malaria Prophylaxis	<i>This document can be accessed on the Navy Pharmacy NKO Page -</i> https://wwwa.nko.navy.mil/portal/navymedicine/fip/home/navypharmacysop?paf_default_view=true
Occupational Safety and Health Administration (OSHA)	http://www.osha.gov
Office of Government Ethics	http://oge.gov
Poison Prevention Packaging Act of 1970.	http://www.cpsc.gov/businfo/pppa.pdf
The Privacy Act of 1974	http://www.justice.gov/opcl/privstat.htm http://www.hhs.gov/foia/privacy/index.html
ScriptPro	http://www.scriptpro.com/
Standard Labor Data Collection and Distribution Application (SLDCADA)	http://www.sldcada.disa.mil/
Standard Navy Medicine Forms	http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx
The TRICARE Management Activity (TMA) Privacy and Civil Liberties Office	http://www.tricare.mil/tma/privacy
TRICARE	http://www.tricare.mil
TRICARE Mail Order Pharmacy (TMOP)	http://www.tricare.mil/homedelivery
TRICARE Pharmacy Program	http://www.military.com/benefits/tricare/tricare-pharmacy-program.html
United States Pharmacopeia (USP)	http://www.usp.org
United States Pharmacopeia (USP) 795 Standards	http://www.pharmacopeia.cn/v29240/usp29nf24s0_c795.html
United States Pharmacopeia (USP) 797 Standards	http://www.usp.org/sites/default/files/usp_pdf/EN/USPNF/key-issues/c797.pdf
Wide Area Workflow (WAWF)	https://wawf.eb.mil/notice.xhtml

Table D-1: Additional References

Navy Pharmacy SOP: Appendix E

Appendix E – Pharmacy Forms and Templates

This appendix contains forms and templates to be used as part of Navy Pharmacy operating procedures.

Standard Navy Medicine Forms

Standard Navy Medicine forms may be obtained through the official Navy Medicine website: <http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx>. The Navy Pharmacy SOP references the following forms included on this site:

- NAVMED 6710/1
- NAVMED 6710/4
- NAVMED 6710/6

To access DD 1289 forms, pharmacy staff should contact their Pharmacy Department Head.

Navy Pharmacy Templates

Additional forms have been included to serve templates for meeting the requirements found within the Navy Pharmacy SOP. These forms may vary by Command but must, at a minimum, contain the information included within the following templates:

Batch Refill Delivery Logs

[Batch Refill Delivery Log](#)

[Missing Refill Report](#)

[Pharmacy Personnel Authorized To Transport Medications Memorandum](#)

Compounding Logs

[Compounded Lot Assignment Book](#)

[Non-Sterile Compounding Log](#)

[Sterile Compounding Log](#)

Crash Cart Logs

[Crash Cart Tray Dispensing Log](#)

[Crash Cart Tray Inventory Record](#)

[Crash Cart Tray Tag Log](#)

Inspection Logs

[Pharmacy Inspection Checklist](#)

[Ward Requisition Form](#)

[Ward/Clinic Inspection Record](#)

[Ward Inspection Report](#)

IV Logs

[IV and Injectable Orders Log](#)

Medication Packaging Logs

[Prepack Medication Log](#)

[Unit Dose Packaging Log](#)

Prescription Transfer Request

[Prescription Transfer Request Form](#)

Navy Pharmacy SOP: Appendix E

Batch Refill Delivery Log (Revised November 2012): DATE _____

Clinic	Tote #	Refer	Tag Number 1	Tag Number 2	Verified	Driver Signature	Received By

PLEASE VERIFY CORRECT PHARMACY LOCATION AS YOU PUT RX'S ON REFILL SHELF *RECEIVING CLINICS PLEASE PRINT YOUR NAME CLEARLY, NO SIGNATURES* *MAKE A COPY AND KEEP IN A BINDER FOR 30 DAYS*

Navy Pharmacy SOP: Appendix E

Missing Refill Report (Revised November 2012): DATE _____

Date	Prescription #	Patient Name	Drug Name	Refrigerated ? (Y/N)	Initials, Completion in CHCS	Refill not delivered / Site belongs to*

*Pharmacies who receive refills belonging to another site should notify the site awaiting the refill and either return the refill to stock or to the Centralized Batch Pharmacy, in accordance with the procedures found in [5.5.1 Receive Refill Prescriptions](#).

**May use different format for log, provided all above information is included

Navy Pharmacy SOP: Appendix E

Pharmacy Personnel Authorized To Transport Medications Memorandum (Revised November 2012)

In the event that pharmacy personnel must transport medications to a secondary location, this memorandum should be completed, signed and carried by the transporter while in possession of medicine.

MEMORANDUM

From: **[NAME OF PHARMACY, MTF, CITY, STATE AND ZIP CODE]**

To: Security Staff, **[MILITARY INSTALLATION, CITY, STATE AND ZIP CODE]**

Subj: *PHARMACY PERSONNEL AUTHORIZED TO TRANSPORT MEDICATIONS*

Date: **[DATE]**

1. The following member is authorized to receive and transport medications from the **[NAME OF PHARMACY]** to **[NAME AND LOCATION OF DELIVERY]** on **[DATE]**.

[NAME AND RANK (IF APPLICABLE) OF TRANSPORTER]

2. This memorandum supersedes all others and is valid only for the date specified.
3. If additional information is required call: **[PHARMACY PHONE NUMBER]**.

**[NAME AND RANK (IF APPLICABLE) OF
PHARMACY DEPARTMENT HEAD]**

Department Head, **[PHARMACY]**

*May use different format for log, provided all above information is included

Navy Pharmacy SOP: Appendix E

Compounded Lot Assignment Book (Revised November 2012)

[illegible]

*May use different format for record, provided all above information is included.

Navy Pharmacy SOP: Appendix E

Non-Sterile Compounding Log (Revised November 2012)

Tech: _____ **RPh:** _____ **Date Compounded:** _____

Insert Order Label Here

If not included on the order label above, provide the following information:

Lot #: _____

Order Contents: _____

Order Compounding Process: _____

*May use different format for log, provided all above information is included

Navy Pharmacy SOP: Appendix E

Sterile Compounding Log (Revised November 2012)

Tech: _____ RPh: _____ Date Compounded: _____

Insert Order Label Here

If not included on the order label above, provide the following information:

Lot #: _____

Order Contents: _____

Order Compounding Process: _____

*May use different format for log, provided all above information is included

Navy Pharmacy SOP: Appendix E

Crash Cart Tray Dispensing Log (Revised November 2012)

[illegible]

*May use different format for log, provided all above information is included.

Navy Pharmacy SOP: Appendix E

Crash Cart Tray Inventory Record (Revised September 2012)

Hospital/Pharmacy Name: _____

Tray Type (e.g., Adult, Pediatric, Infant): _____ Tag Number: _____

Ward: _____ Most Recent Expiration Date: _____

Tech: _____ RPh: _____ Date Filled: _____

A pharmacist and technician must sign above to indicate that this tray is ready to be issued to the ward. This form must be kept in the tray.

MEDICATION	QTY	EXP. DATE

*May use different format for record, provided all above information is included.

Navy Pharmacy SOP: Appendix E

Crash Cart Tray Tag Log (September July 2012)

[illegible]

*May use different format for log, provided all above information is included.

Navy Pharmacy SOP: Appendix E

Pharmacy Inspection Checklist (Revised November 2012)

Pharmacy Name: _____

Inspection Date (completed record due by COB the ____ of each month): _____

Pharmacy Representative: _____

Printed/Signed Name of Reviewer: _____

1. PHARMACY SPACES SECURITY	YES	NO	N/A	COMMENTS
a. Restricted Area sign posted on all doors				
b. Access door(s) secured, cipher locks or similar				
c. Staff badges displayed				
d. Dispensing and external windows securable				
e. Intrusion alarms checked monthly; action taken documented				
f. Controlled substance areas are secure per MANMED Chapter 21 (C-II's double-locked, etc.)				
g. Vault combination changed as required				
h. Vault access list completed/posted				
2. REFRIGERATOR / FREEZER	YES	NO	N/A	COMMENTS
a. Refrigerated items properly stored				
b. Temperature log or electronic monitoring maintained				
c. Out of temperature range actions documented				
d. Current refrigerator temperature within range (36-46 deg F)				
e. Medication only and food only refrigerators separate and properly labeled				
f. Refrigerators/freezers clean and defrosted				

Navy Pharmacy SOP: Appendix E

Pharmacy Inspection Checklist, Page 2 (Revised November 2012)

3. SUPPLIES AND STOCK	YES	NO	N/A	COMMENTS
a. All medications on random check are in date				
b. Appropriate disposal of expired/discarded medications				
c. Expired/Returned goods segregated from regular stock and clearly labeled				
d. All medications properly labeled				
e. HAM/SALAD meds prominently labeled				
f. Dosage forms labeled and separated (e.g., topicals separated from injectables)				
4. REFERENCE MATERIALS	YES	NO	N/A	COMMENTS
a. Navy Pharmacy SOP readily retrievable				
b. Local SOP readily retrievable				
c. Current MANMED Chapter 21 readily retrievable				
d. "Do Not Use Abbreviation" list posted				
e. Current HAM/SALAD list posted				
f. "Must-call pharmacist" list posted				
5. SAFETY	YES	NO	N/A	COMMENTS
a. Caustic Materials/HAZMAT stored properly				
b. MSDS available for all HAZMATs				
c. Chemotherapy medications stored separately				
d. Chemotherapy spill kit available				
e. Personal Protective Equipment (PPE) available				
f. Poison Control phone number displayed				
g. Open corridors, 4' minimum				
h. Store rooms uncluttered, 18" clearance from sprinklers minimum				
i. Eyewash stations present, testing documented				
j. No food/drinks where medications are handled/stored				

Navy Pharmacy SOP: Appendix E

Pharmacy Inspection Checklist, Page 3 (Revised November 2012)

6. RECORD KEEPING	YES	NO	N/A	COMMENTS
a. Department Logbook present/current				
b. All prescription records on file for two (2) years				
c. Prescriptions filed numerically				
d. CII prescriptions filed separately; CIII-CV filed separately				
e. Narcotic inventory and records complete				
f. CSIB inventory completed at least quarterly				
g. Letter of Appointment for bulk custodian				
h. Medication storage area inspections readily retrievable				
7. TRAINING	YES	NO	N/A	COMMENTS
a. Training files present and up-to-date				
b. Safety training completed upon check-in and as needed				
c. Competencies completed/readily retrievable				
8. QUALITY ASSURANCE	YES	NO	N/A	COMMENTS
a. PSR's submitted for Medication Errors/Near Misses/ADR's				
b. PDTS reports corrected weekly				
c. PDTS Over \$2k reports submitted on time				
d. All clinical overrides reviewed by a pharmacist and action taken documented				
9. PHARMACY OPERATIONS	YES	NO	N/A	COMMENTS
a. Overall appearance clean and orderly				
b. Hours of operation prominently posted				
c. Protected patient information disposed of properly				
d. Equipment operational, appropriate preventive maintenance completed/logged				

Navy Pharmacy SOP: Appendix E

Pharmacy Inspection Checklist, Page 4

(Revised November 2012)

ADDITIONAL COMMENTS (Attach additional sheets or documents as needed.):

Completed copies to be filed by each site, as appropriate.

*May use different format for log, provided all above information is included

Navy Pharmacy SOP: Appendix E

Ward Requisition Form (Revised November 2012)

Ward Clinic: _____ Date: _____

Submitted By: _____

Received By: _____ Date: _____

Drug Description Strength Dosage Form			Drug Description Strength Dosage Form		
Oral Medications	Amt.	Amt. Issued	Injectable Medications	Amt.	Amt. Issued
External and Misc. Medications			Medications Requiring Refrigeration		
			STAT Medications		
			Filled By	Checked by	Count

*May use different format for log, provided all above information is included

Navy Pharmacy SOP: Appendix E

Ward/Clinic Inspection Record (Revised November 2012)

Hospital/Clinic Name: _____

Ward Inspected: _____

Inspection Date (completed record due by COB the _____ of each month): _____

	Standards	Compliant	Non-Compliant	N/A
1	The area is clean, neat and well organized			
2	Only P&T authorized medications are present*			
3	No sample medications are present			
4	Drugs requiring special storage are properly stored (e.g., light, refrigeration)			
5	There are no expired, recalled, broken or mislabeled medications in the ADC unit			
6	There are no expired, recalled, broken or mislabeled medications in the ward/clinic			
7	Medications are locked up or are in a secure location			
8	Reconstituted medications contain: expiration date, concentration, initials			
9	No food or drinks are stored in the refrigerators used for medications			
10	Separate refrigerators are clearly labeled as "Medications" and "Food"			
11	Refrigerator temperatures are logged daily or tracked by an electronic monitoring device			
12	Refrigerator temperature between 2-8 degrees C / 36-48 degrees F			
13	If temperature is out of range, did the ward document action?			
14	Refrigerator is clean and free of excessive frost			
15	If sterile compounding is required, there is a designated area for compounding			
16	Crash cart tray is sealed and within medication expiration date			
17	Look-Alike Sound-Alike (LASA) and High-Alert Medications (HAM) are stored accordingly to the Command policy.			

Discrepancies (if YES, detail on back of form): _____

Print and sign names:

Pharmacy Inspector: _____ Ward Division Officer: _____

Pharmacy Officer: _____ Date Given to Pharmacy Officer: _____

* To be used in conjunction with the Command list of P&T authorized medications (i.e. Command formulary and approved non-formulary medications)

Navy Pharmacy SOP: Appendix E

Ward/Clinic Inspection Record, Page 2 (Revised November 2012)

Discrepancies (provide detail from previous page):

Corrective Actions:

*May use different format for log, provided all above information is included.

Navy Pharmacy SOP: Appendix E

Ward Inspection Report (Revised December 2012)

Ward	Inspector	Last Inspected	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Navy Pharmacy SOP: Appendix E

Ward Inspection Report, Page 2 (Revised December 2012)

Key	
1.	The area is not clean, nor neat.
2.	Unauthorized medications and supplies are present.
3.	Sample medications are present.
4.	Drugs requiring special storage are improperly stored (e.g., light, refrigerator)
5.	There are expired, recalled, broken or misplaced medications in the Automated Dispensing Cabinet (Pyxis or Omnicell).
6.	There are expired, recalled, broken, or misplaced medications in the ward.
7.	Medications are not locked up nor are in a secure location.
8.	Reconstituted medications do not contain date, concentration, and initials.
9.	Food or drinks are stored in the refrigerators used for medications.
10.	Refrigerator temperatures are not logged daily.
11.	The refrigerator is neither clean nor free of excessive frost.
12.	The refrigerator temperature is not between 2 and 8 degree C or 36 and 46 degree F.
13.	If the temperatures are out of range, did you inform ward about this issue?
14.	The refrigerator is not clearly marked "For Medication Only".
15.	Metric/Apothecaries conversion chart is not displayed.
16.	Poison Control number is not displayed on all telephones.
17.	Crash cart log does not reflect monthly check by ward staff.
18.	Crash cart is not checked by pharmacy staff.
19.	Cerebyx vials are expired.
20.	There are concentrated potassium chloride vials (i.e. 2 MeQ/ml) or other electrolyte vials (i.e. NACL 23.4% on the ward).
21.	The ward is compliant with all applicable standards.

Navy Pharmacy SOP: Appendix E

IV or Injectable Orders Log (Revised November 2012)

[illegible]

*May use different format for log, provided all above information is included.

Navy Pharmacy SOP: Appendix E

Prepack Medication Log (Revised November 2012)

Tech: _____ **RPh:** _____ **Expiration Date:** _____

Insert Prepack Medication Label Here

If not included on the order label above, provide the following information:

Lot #: _____ **# Labels:** _____ **Date Prepared:** _____

Comments: _____

*May use different format for log, provided all above information is included

Navy Pharmacy SOP: Appendix E

Unit Dose Packaging Log (Revised November 2012)

Tech: _____ RPh: _____ Expiration Date: _____

Insert Order Label Here

If not included on the order label above, provide the following information:

Lot #: _____ # Labels: _____ Date Prepared: _____

Comments: _____

*May use different format for log, provided all above information is included.

Navy Pharmacy SOP: Appendix E

Prescription Transfer Request Form

This form can be utilized when pharmacy personnel must transfer a prescription to a new pharmacy location. Pharmacy personnel should include as much information as possible when completing the form.

RX		Transfer Form		RX			
Date:							
<i>Patient Information</i>			<i>Provider Information</i>				
Name:			Name:				
Address:			Phone #:				
Last 4:			DEA:				
DOB:			NPI #:				
<i>RX Information</i>			<i>Pharmacy Information</i>				
Original RX Number:			Name/Store Number:				
Refills Left:			Phone:				
Written Date:			DEA (for Controls):				
Original Fill:			RPH Name:				
Last Fill:			Receiving RPH:				

Navy Pharmacy SOP: Appendix F

Appendix F – Documenting CHCS Clinical Overrides

This appendix contains information on how to document clinical override comments in CHCS. When documenting comments in CHCS, pharmacy staff is encouraged to follow the best practices outlined below.

- [Allergies/Hypersensitivities](#)
- [Drug-Drug\(s\) Interaction](#)
- [Class Overlap](#)
- [Duplication of Therapy](#)
- [Refill Too Soon](#)

Documentation space in CHCS is limited. Staff should be as informative as possible within the space constraints by utilizing these guidelines and best practices.

Terms to Avoid

When documenting comments in CHCS, avoid using the following:

- ✓ "OK"
- ✓ "."
- ✓ "<space bar>"
- ✓ "NEW RX"

Navy Pharmacy SOP: Appendix F

Allergies/Hypersensitivities

When clearing a clinical screening for an allergy the pharmacist or pharmacy technician should include:

- ✓ Medication to which the patient had an allergy.
- ✓ How the allergy manifested itself.
- ✓ How the patient has been doing on current therapy.
- ✓ Duration of current therapy.
- ✓ If therapy is a renewal.
- ✓ Pharmacist's name who authorized override, if pharmacist is not logged into CHCS.
- ✓ For new therapies, the process for clearing and monitoring should be recorded.

****Standard: Pt alg to<drug>- <reaction>-<current patient status>-<duration of therapy>**

Example 1

Sarah Smith has an allergy to a Sulfa medication and is attempting to fill a hydrochlorothiazide prescription, which she has been on for three years, with no allergic reaction.

Documentation: *Pt alg to bactrim-rash-continuing HZTC for 3 yrs-no signs of alg*

Example 2

Bob Jones has a noted allergy to NSAIDs and is attempting to fill an aspirin prescription, which he is starting for cardiac reasons.

Documentation: *Pt alg to motrin-hives-called MD on MM/DD/YY.Dr blank and pt aware of alg. Pt will monitor*

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Drug-Drug(s) Interaction

When clearing a clinical screening for a drug that has an interaction with one or more drugs in the patient's profile, the pharmacist or pharmacy technician should include:

- ✓ Name(s) of drug(s) which are interacting
- ✓ Education type given and whom it is given
- ✓ If it is a renewal
- ✓ Update of patient's status
- ✓ Monitoring on current therapy
- ✓ Note if a provider was called for clarification
- ✓ Name of the pharmacist who authorized the override if severe or contraindication

****Standard: <drug>/<drug>/<education>/<to whom>/<current status of patient>/<monitoring>**

Example 1

Sarah Smith has been taking magnesium for a number of years for chronic hypomagnesaemia. She comes to your window today with a prescription for levaquin.

Documentation: *Magnesium/levaquin-explained importance of time separation to pt.*

Example 2

Bob Jones has been taking warfarin for his atrial fibrillation for a number of years now. He comes to your window today with renewal prescriptions for aspirin and phenytoin.

Documentation: *warfarin/asa/phenytoin-explained effects.pt stable.monitors INR Qmonth*

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Class Overlap

When clearing a clinical screening for a drug that has a class overlap (i.e. Antidiabetics, antihyperlipidemics, anxiolytics/hypnotics), the pharmacist or pharmacy technician should indicate:

- ✓ Rationale for class overlap based on patient/doctor response
- ✓ If it is a renewal
- ✓ Update of patient's status
- ✓ Monitoring (if necessary)

****Standard: <drug>/<drug>/<rationale>/<current patient status(renewal)>/<monitoring (as needed)>**

Example 1

Sarah Smith has been on Lantus and Novolog for diabetic management for a number of years. She presents renewal prescriptions for both medications at your window today.

Documentation: *Pt continuing lantus, novolog therapy for DM2.well controlled for 5 yrs*

Example 2

Bob Jones has been taking simvastatin for a number of years for his cholesterol. He comes to your window today with a prescription for Zetia.

Documentation: *Pt indicates MD added Zetia/Zocor to get TGs and LDL at goal*

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Duplication of Therapy

When clearing a duplication of therapy, review of the agents should be completed and documented as appropriate.

****Standard: <rationale>/<current status of patient>**

Example 1

Bob Jones has been taking synthroid 88 mcg and 100 mcg alternating for a number of years. He comes to your window today with renewals for both with directions on both to take every other day.

Documentation: *Pt alternates 100 mcg and 88 mcg each day and is stable on therapy*

***If information like this is learned through interview consider adding to sig

Navy Pharmacy SOP: Appendix F

Refill Too Soon

When clearing a refill that is too soon communication with the patient is paramount. Remind the patient of appropriate policies and/or when and where they last picked up their medication.

Comment must detail:

- ✓ Where and when the patient picked up the medicine
- ✓ How many (Quantity/Day Supply) they picked up

****Standard:** <Pt picked up <drug> at <pharmacy> on <date> for <quantity/day supply>

Example 1

Sarah Smith has called a refill for Micardis into Audiocare. You notice that she just had this filled at Rite Drug with a 90 day supply one week ago.

Documentation: *Pt picked up micardis at Rite Drug on MM/DD/YY for 90 DS.*

Remove Refill Error and rewrite documentation above

Navy Pharmacy SOP: Appendix G

Appendix G – Joint Commission Crosswalk

The Joint Commission (TJC) Crosswalk (*Table G-1: TJC Crosswalk*) provides each TJC Medication Management (MM) Standard, including the relevant Element of Performance (EP), and aligns it to Navy Pharmacy SOP location that addresses the JC EP. By providing a clear and easy use to reference, the TJC Crosswalk supports adherence to TJC requirements.

In addition to the table in Appendix G, in-text icons can be found within the Navy Pharmacy SOP. These icons indicate that the SOP section aligns to a specific TJC EP. Icons are also hyperlinked to the appropriate location in Appendix G.

For additional information on TJC certification, accreditation, and standards, refer to [The Joint Commission website](#) or contact your Navy Medicine Regional Pharmacist.

The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
MM.01.01.01: The hospital plans its medication management processes			
1	The organization has a written policy that describes that the following information about the patient is accessible to licensed independent practitioners and staff who participate in the management of the patient's medications: <ul style="list-style-type: none">• Age• Sex• Diagnoses• Allergies• Sensitivities• Current medications• Height and weight (when necessary)• Pregnancy and lactation information (when necessary)• Laboratory results (when necessary)• Any additional information required by the organization	2.2.4 Requirements for Order Entry	
		3.2.1 Prescription Information Requirements	
MM 01.01.03: The hospital safely manages high-alert and hazardous medications.			
1	The hospital identifies, in writing, its high-alert and hazardous medications	7.7.1 Pharmacy Safety (High-Alert Medications)	
2	The hospital has a process for managing high-alert and hazardous medications.		
MM.01.02.01: The hospital addresses the safe use of look-alike/sound-alike medications.			

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
1	The hospital develops a list of look-alike/sound-alike medications it stores, dispenses, or administers. <u>Note:</u> One source of look-alike/sound-alike medications is The Institute for Safe Medication Practices (http://www.ismp.org/Tools/confuseddrugnames.pdf)	7.7.1 Pharmacy Safety (Look-Alike/Sound Alike Medications and Confused Drug Names)	
2	The hospital takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.		
3	The hospital annually reviews and, as necessary, revises its list of look-alike/sound-alike medications.		
MM.02.01.01: The hospital selects and procures medications.			
1	Members of the medical staff, licensed independent practitioners, pharmacists, and staff involved in ordering, dispensing, administering, and/or monitoring the effects of medications develop written criteria for determining which medications are available for dispensing or administering to patients.	7.1.6 Committee Involvement	
2	The hospital develops and approves criteria for selecting medications, which, at a minimum, include the following: <ul style="list-style-type: none">• Indications for use• Effectiveness• Drug interactions• Potential for errors and abuse• Adverse drug events• Sentinel event advisories• Population(s) served (for example, pediatrics, geriatrics)• Other risks• Costs		
3	Before using a medication new to the hospital, the hospital determines a method to monitor the response of the patient.		
4	The hospital maintains a formulary, including medication strength and dosage. <u>Note 1:</u> Sample medications are not required to be on the formulary. <u>Note 2:</u> In some settings, the term "list of medications available for use" is used instead of "formulary." The terms are synonymous.		
5	The hospital makes its formulary readily available to those involved in medication management.		
6	The hospital standardizes and limits the number of drug concentrations available to meet patient care needs.	2.2.5 Must Contact Pharmacist List	
7	The hospital has a process to select, approve, and procure medications that are not on its formulary.	6.1 Manage Pharmacy Supply	
		7.1.6 Committee Involvement	

Navy Pharmacy SOP: Appendix G

The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
9	Medications designated as available for dispensing or administration are reviewed at least annually based on emerging safety and efficacy information.	7.1.6 Committee Involvement	
10	The hospital has a process to communicate medication shortages and outages to licensed independent practitioners and staff who participate in medication management.	6.1 Manage Pharmacy Supply	
12	The hospital develops and approves written medication substitution protocols to be used in the event of a medication shortage or outage.	7.1.6 Committee Involvement	
14	The hospital has a process to communicate to licensed independent practitioners and staff who participate in medication management about the medication substitution protocols for shortages or outages.	6.1 Manage Pharmacy Supply	
MM.03.01.01: The hospital safely stores medications.			
2	The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.	6.1 Manage Pharmacy Supply	
3	The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation. <i>Note: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.</i>	7.1.4 Pharmacy Access	
4	The hospital has a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, security, disposition, and return to storage.	This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	
6	The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.	2.5 Ward Stocking	
7	All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.	2.3.1 Prepare Inpatient Medication Labels (Patient-Specific Medications)	
		3.3.4 Prepare Prescription Labels	
8	The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.	7.7.8 Expired, Damaged, and/or Contaminated Medications	

Navy Pharmacy SOP: Appendix G

The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (<i>as needed</i>)
9	The hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)	7.7.1 Pharmacy Safety (High Alert Medications)	
10	Medications in patient care areas are available in the most ready-to-administer forms commercially available or, if feasible, in unit-doses that have been repackaged by the pharmacy or a licensed repackager.	7.4.3 ADC Stock Management	
18	The hospital periodically inspects all medication storage areas.	7.8 Inspections	
MM.03.01.03: The hospital safely manages emergency medications.			
1	Hospital leaders, in conjunction with members of the medical staff and licensed independent practitioners, decide which emergency medications and their associated supplies will be readily accessible in patient care areas based on the population served.	2.5.3 Stock Crash Cart Trays	
2	Emergency medications and their associated supplies are readily accessible in patient care areas. (See also PC.03.01.01, EP 8)		
3	Whenever possible, emergency medications are available in unit-dose, age-specific, and ready-to-administer forms.		
6	When emergency medications or supplies are used, the hospital replaces them as soon as possible to maintain a full stock.		
MM.03.01.05: The hospital safely controls medications brought into the hospital by patients, their families, or licensed independent practitioners.			
1	The hospital defines when medications brought into the hospital by patients, their families, or licensed independent practitioners can be administered.	2.1 Patient Arrival and Admission	
2	Before use or administration of a medication brought into the hospital by a patient, his or her family, or a licensed independent practitioner, the hospital identifies the medication and visually evaluates the medication's integrity.		
3	The hospital informs the prescriber and patient if the medications brought into the hospital by patients, their families, or licensed independent practitioners are not permitted.	This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
MM04.01.01: Medication orders are clear and accurate.			
1	<p>The hospital has a written policy that identifies the specific types of medication orders that it deems acceptable for use.</p> <p><i>Note: There are several different types of medication orders. Medication orders commonly used include the following:</i></p> <ul style="list-style-type: none"> • <i>As needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom</i> • <i>Standing orders: A pre-written medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances</i> • <i>Automatic stop orders: Orders that include a date or time to discontinue a medication</i> • <i>Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status</i> • <i>Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval</i> • <i>Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status</i> • <i>Orders for compounded drugs or drug mixtures not commercially available</i> • <i>Orders for medication-related devices (for example, nebulizers, catheters)</i> • <i>Orders for investigational medications</i> • <i>Orders for herbal products</i> • <i>Orders for medications at discharge or transfer</i> 	<p>This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.</p>	
2	The hospital has a written policy that defines the following: The required elements of a complete medication order.	2.2.4 Requirements for Order Entry	
		3.2.1 Prescription Information Requirements	
3	The hospital has a written policy that defines the following: When indication for use is required on a medication order.	2.1.3 Perform Profile Review	
4	The hospital has a written policy that defines the following: The precautions for ordering medications with look-alike or sound-alike names.	7.7.1 Pharmacy Safety (LASA)	
5	The hospital has a written policy that defines the following: Actions to take when medication orders are incomplete, illegible, or unclear.	2.2.4 Requirements for Order Entry	
		2.4.1 Final Order Verification	

Navy Pharmacy SOP: Appendix G

The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (<i>as needed</i>)
6	The hospital minimizes the use of verbal and telephone medication orders.	2.2.4 Requirements for Order Entry	
		2.4.1 Final Order Verification	
7	The hospital reviews and updates preprinted order sheets, within time frames it identifies or sooner if necessary, based on current evidence and practice.	This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	
8	The hospital prohibits summary (blanket) orders to resume previous medications.	2.2.4 Requirements for Order Entry	
9	A diagnosis, condition, or indication for use exists for each medication ordered. <i>Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.</i>	This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	
10	The hospital defines, in writing, the circumstances for which weight-based dosing is required for pediatric populations. (See also MM.01.01.01, EP 1)	2.2.6 Enter Order into CHCS	
		3.1.6 Verify Patient Weight	
		3.4.2 Additional Prescription Verification Processes (Weight and/or Age Specific Prescription)	
14	The hospital requires an order from a doctor of medicine or osteopathy, or, as permitted by law and regulation, a hospital-specific protocol(s) approved by a doctor of medicine or osteopathy, to administer influenza and pneumococcal polysaccharide vaccines.	This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
MM.05.01.01: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.			
1	<p>Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation.</p> <p><i>Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient back-up. The first exception allows medications ordered by a licensed independent practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A licensed independent practitioner is not required to remain at the bedside when the medication is administered. However, a licensed independent practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient.</i></p> <p><i>Note 2: A hospital's radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the licensed independent practitioner in the direct supervision of a patient during and after IV contrast media is administered including the licensed independent practitioner's timely intervention in the event of a patient emergency.</i></p>	2.2.5 Must Contact Pharmacist List	
2	When an on-site pharmacy is not open 24 hours a day, 7 days a week, a health care professional determined to be qualified by the hospital reviews the medication order in the pharmacist's absence.	2.2.8 Review Order (LIP/Nurse)	
3	When an on-site pharmacy is not open 24 hours a day, 7 days a week, a pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens.		
4	All medication orders are reviewed for the following: Patient allergies or potential sensitivities.	2.2.7 Review Clinical Warnings	
5	All medication orders are reviewed for the following: Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.	2.1.3 Perform Profile Review	
6	All medication orders are reviewed for the following: The appropriateness of the medication, dose, frequency, and route of administration.	2.1.3 Perform Profile Review	

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (<i>as needed</i>)
7	All medication orders are reviewed for the following: Current or potential impact as indicated by laboratory values.	2.2.4 Requirements for Order Entry	
8	All medication orders are reviewed for the following: Therapeutic duplication.	2.2.7 Review Clinical Warnings	
9	All medication orders are reviewed for the following: Other contraindications.		
11	After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.	2.1.3 Perform Profile Review	
		2.2.4 Requirements for Order Entry	
MM.05.01.07: The hospital safely prepares medications.			
1	A pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product’s stability is short.	8.1.2 Prepare Sterile Compounded Medication	
2	Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.	8.1 Sterile Compounded Medication	
3	During preparation, staff visually inspect the medication for particulates, discoloration, or other loss of integrity. (See also MM.03.01.05, EP 2; MM.06.01.01, EP 4)	8.1.2 Prepare Sterile Compounded Medication	
4	The hospital uses a laminar airflow hood or other ISO Class 5 environment in the pharmacy for preparing intravenous (IV) admixture or any sterile product that will not be used within 24 hours.	8.1.2 Prepare Sterile Compounded Medication (Non-Immediate Use)	
MM.05.01.09: Medications are labeled.			
1	Medication containers are labeled whenever medications are prepared but not immediately administered. <u>Note:</u> An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.	8.1.2 Prepare Sterile Compounded Medication	
2	Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice.	2.3.1 Prepare Inpatient Medication Labels (Patient-Specific Medications)	
		3.3.4 Prepare Prescription Labels	

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (<i>as needed</i>)
3	All medications prepared in the hospital are correctly labeled with the following: Medication name, strength, and amount (if not apparent from the container).	2.3.1 Prepare Inpatient Medication Labels (Patient-Specific Medications)	
		3.2.1 Prescription Information Requirements	
4	All medications prepared in the hospital are correctly labeled with the following: Expiration date when not used within 24 hours.	2.3.1 Prepare Inpatient Medication Labels (Patient-Specific Medications)	
5	All medications prepared in the hospital are correctly labeled with the following: Expiration time when expiration occurs in less than 24 hours.		
6	All medications prepared in the hospital are correctly labeled with the following: The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas.	2.3.1 Prepare Inpatient Medication Labels (Additional Labeling Requirements)	
7	When preparing individualized medications for multiple patients, the label also includes the following: The patient's name.	2.3.1 Prepare Inpatient Medication Labels (Patient-Specific Medications)	
8	When preparing individualized medications for multiple patients, the label also includes the following: The location where the medication is to be delivered. (See also NPSG.01.01.01, EP 1) <i>Note: The location is not to be used as a patient identifier during administration of a medication, as indicated by NPSG.01.01.01, EP 1.</i>		
9	When preparing individualized medications for multiple patients, the label also includes the following: Directions for use and applicable accessory and cautionary instructions.		
10	When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: The patient's name.		
11	When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: The location where the medication is to be delivered. (See also NPSG.01.01.01, EP 1) <i>Note: The location is not to be used as a patient identifier during administration of a medication, as indicated by NPSG.01.01.01, EP 1.</i>		
12	When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: Directions for use and applicable accessory and cautionary instructions.		

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (<i>as needed</i>)
MM.05.01.11: The hospital safely dispenses medications.			
1	The hospital dispenses quantities of medications that are consistent with patient needs.	2.3.3 Prepare Unit Dose Orders	
2	The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. <i>Note: Dispensing practices and recordkeeping include antidiversion strategies.</i>	3.3.6 Document and File Prescriptions Filled	
		9.1 Controlled Substance Prescription Preparation, Filling, and Dispensing	
3	The hospital dispenses medications within time frames it defines to meet patient needs.	2.1.2 Prioritize New Patient Medication Order	
4	Medications are dispensed in the most ready-to-administer forms commercially available and, if feasible, in unit doses that have been repackaged by the pharmacy or licensed repackager.	2.3.3 Prepare Unit Dose Orders	
MM.05.01.13: The hospital safely obtains medications when the pharmacy is closed.			
1	The hospital has a process for providing medications to meet patient needs when the pharmacy is closed.	7.4 Automated Dispensing Cabinets (ADCs)	
2	When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Medications available are limited to those approved by the hospital.	7.1.6 Committee Involvement	
3	When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: The hospital stores and secures the medications approved for use outside of the pharmacy.	7.4.1 ADC Patient Settings	
4	When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Only trained, designated prescribers and nurses are permitted access to approved medications.		
5	When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Quality control procedures (such as an independent second check by another individual or a secondary verification built into the system such as bar coding) are in place to prevent medication retrieval errors.	2.2.8 Review Order (LIP/Nurse)	
		This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (<i>as needed</i>)
6	When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: The hospital arranges for a qualified pharmacist to be available either on-call or at another location (for example, at another organization that has 24-hour pharmacy service) to answer questions or provide medications beyond those accessible to non-pharmacy staff.	2.2.5 Must Contact Pharmacist List	
7	The hospital implements its process for providing medications to meet patient needs when the pharmacy is closed.	2.4.6 Verify Order (Pharmacy Technician)	
MM.05.01.17: The hospital follows a process to retrieve recalled or discontinued medications.			
1	The hospital has a written policy describing how it will retrieve and handle medications within the hospital that are recalled or discontinued for safety reasons by the manufacturer or the U.S. Food and Drug Administration (FDA). (See also EC.02.01.01, EP 11)	6.3 Manage MMQC Drug Recalls	
3	When a medication is recalled or discontinued for safety reasons by the manufacturer or the U.S. Food and Drug Administration (FDA), the hospital notifies the prescribers and those who dispense or administer the medication. (See also EC.02.01.01, EP 11)	6.1 Manage Pharmacy Supply	
4	When required by law and regulation or hospital policy, the hospital informs patients that their medication has been recalled or discontinued for safety reasons by the manufacturer or the U.S. Food and Drug Administration (FDA). (See also EC.02.01.01, EP 11)		
MM.05.01.19: The hospital safely manages returned medications.			
1	The hospital determines under what circumstances unused, expired, or returned medications will be managed by the pharmacy or the hospital.	7.7.8 Expired, Damaged, and/or Contaminated Medications	
2	When the hospital accepts unused, expired, or returned medications, it has a process for returning medications to the pharmacy’s control that includes procedures for preventing diversion.	This EP requires collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	
3	The hospital determines if and when outside sources are used for destruction of medications.	2.5.6 Return Inpatient Medications to Pharmacy	

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
<i>MM.06.01.01: The hospital safely administers medications.</i>			
1	The hospital defines, in writing, licensed independent practitioners and the clinical staff disciplines that are authorized to administer medication, with or without supervision, in accordance with law and regulation. (See also MM.06.01.03, EP 1)	These EPs require collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	
2	Only authorized licensed independent practitioners and clinical staff administer medications. <u>Note:</u> This does not prohibit self-administration of medications by patients, when indicated. (See also MM.06.01.03, EP 1)		
3	Before administration, the individual administering the medication does the following: Verifies that the medication selected matches the medication order and product label.		
4	Before administration, the individual administering the medication does the following: Visually inspects the medication for particulates, discoloration, or other loss of integrity. (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3)		
5	Before administration, the individual administering the medication does the following: Verifies that the medication has not expired.		
6	Before administration, the individual administering the medication does the following: Verifies that no contraindications exist.		
7	Before administration, the individual administering the medication does the following: Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route.		
8	Before administration, the individual administering the medication does the following: Discusses any unresolved concerns about the medication with the patient's licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient's care, treatment, and services.		
9	Before administering a new medication, the patient or family is informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication. (See also MM.06.01.03, EPs 3-6; PC.02.03.01, EP 10)		

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
MM.06.01.03: Self-administered medications are administered safely and accurately.			
1	If self-administration of medications is allowed, written processes that address training, supervision, and documentation guide the safe and accurate self-administration of medications or the administration of medications by a family member. (See also MM.06.01.01, EPs 1 and 2)	These EPs require collaboration among multi-disciplinary medical staff. It will be addressed in other command documents outside of the Navy Pharmacy SOP.	
3	The hospital educates patients and families involved in self-administration about the following: Medication name, type, and reason for use. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)		
4	The hospital educates patients and families involved in self-administration about the following: How to administer medication, including process, time, frequency, route, and dose. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)		
5	The hospital educates patients and families involved in self-administration about the following: Anticipated actions and potential side effects of the medication administered. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)		
6	The hospital educates patients and families involved in self-administration about the following: Monitoring the effects of the medication. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)		
7	The hospital determines that the patient or the family member who administers the medication is competent at medication administration before allowing him or her to administer medications.		
MM.06.01.05: The hospital safely manages investigational medications.			
1	The hospital has a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring.	7.7.5 Investigational Protocols	
2	The hospital's written process for the use of investigational medications specifies that the pharmacy controls the storage, dispensing, labeling, and distribution of investigational medications.		
3	The written process for the use of investigational medications specifies that when a patient is involved in an investigational protocol that is independent of the hospital, the hospital evaluates and, if no contraindication exists, accommodates the patient's continued participation in the protocol.		

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The Joint Commission Crosswalk			
EP	TJC Standard	SOP Location	Additional Command Policies or Site Comments (as needed)
MM.07.01.03: The hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.			
1	The hospital has a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.	7.7.3 Patient Safety Program	
2	The hospital has a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or medication error.		
3	The hospital complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors.		
MM.08.01.01: The hospital evaluates the effectiveness of its medication management system.			
1	The hospital collects data on the performance of its medication management system. (See also PI.01.01.01, EPs 14 and 15)	7.7.3 Patient Safety Program	
2	The hospital analyzes data on its medication management system.		
3	The hospital compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system.		
4	The hospital reviews the literature and other external sources for new technologies and best practices.	7.1.10 Pharmacy Management Reports	
5	Based on analysis of its data, as well as review of the literature for new technologies and best practices, the hospital identifies opportunities for improvement in its medication management system.		
6	The hospital takes action on improvement opportunities identified as priorities for its medication management system.		
7	The hospital evaluates its actions to confirm that they resulted in improvements for its medication management system.	7.7.3 Patient Safety Program	
8	The hospital takes additional action when planned improvements for its medication management processes are either not achieved or not sustained.		
Notes: The MM EPs listed below measure the implementation of corresponding MM EEPs outlined throughout Table G-1. Therefore, compliance with these MM EPs is consequently achieved by adhering to the SOP sections outlined above: ❖ MM 01.01.01/2 ❖ MM 02.01.01/11 ❖ MM 03.01.01/5 ❖ MM 05.01.19/4 ❖ MM 07.01.03/5 ❖ MM 01.01.03/3 ❖ MM 02.01.01/13 ❖ MM 04.01.01/13 ❖ MM 06.01.03/2 ❖ MM 02.01.01/8 ❖ MM 02.01.01/15 ❖ MM 05.01.17/2 ❖ MM 06.01.05/4 The following MM EPs are not included in the JC Crosswalk because they are deemed not applicable to Navy Pharmacy Operations: ❖ MM 01.01.03/5 ❖ MM 04.01.01/15 ❖ MM 05.01.07/5 ❖ MM 07.01.03/6 ❖ MM 03.01.01/19 ❖ MM 04.01.01/21 ❖ MM 05.01.07/6			

Table G-1: TJC Crosswalk

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Appendix H – Pharmacy Management Reports

In support of Navy Pharmacy workflow management, the Pharmacy Department Head shall utilize available electronic reporting functions.

These reports include, but are not limited to, the following:

- [CHCS Reports](#)
- [Department of Defense Pharmacoeconomic Center \(PEC\)/Pharmacy Operations Center \(POC\) Reports](#)

CHCS Reports

For a complete list of standardized reports available through Composite Health Care System (CHCS), refer to the CHCS Online Users Manual “OLUM.” Available CHCS reports include, but are not limited to, the following:

- **Drug Utilization Review Menu (DUR):** This menu contains options that allow the user to display or print outpatient, unit dose, and IV Drug Utilization Review (DUR) reports. All DUR reports allow the user to define sort criteria such as divisions, sites within divisions, and display output. The reports include a line count on the primary sort that is chosen. In addition, this process may be utilized in the event of a drug recall.
 - *IV DUR Report (IDU)*
 - *Outpatient DUR Report (ODU)*
 - *Unit Dose DUR Report (UDU)*
- **General Pharmacy Reports (GER):** This menu contains options that allow the user to display or print data from all pharmacy areas. For example, the user can generate ad hoc reports, MEPRS reports, product activity reports showing the product activity in the inpatient and outpatient pharmacies, and stock issue movement reports that display information on issues to clinics and wards.
 - *Ad Hoc Report Menu (ADH):* This menu allows the user to create ad hoc reports using data in any of the system files using the FileMan database management system user interface. Options include printing, file search and sorting, inquiring, and listing file attributes.

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- *Pharmacy Site Data Quality (DQ) Report (DQS)*: The Pharmacy module in CHCS is unique in that it does not use entries in the Hospital Location file to define the default Performing Medical Expense and Performance Reporting System (MEPRS) code. Command MEPRS coordinator should be notified if there are any apparent discrepancies in this report. In fact, no Hospital Location entries are used to define Pharmacy entities in CHCS. Instead, Pharmacy uses "site" file parameters to define each type of Pharmacy activity. For workload and data quality, the Performing MEPRS code is the most important data value in any Pharmacy Site file. This report should be generated to validate the Performing MEPRS codes for Pharmacy:
 - Outpatient Sites [Outpatient Prescriptions (Rx)]
 - IV Room [IV]
 - Inpatient Sites [Unit Dose (Inpatient Medications)]
 - Controlled Inventory Vault [Narcotics]
- *PHR Workload Exception Report (EXC)*: This menu option reports workload associated with invalid and/or inactive MEPRS Codes/Defense Medical Information System (DMIS) IDs. The default Start Date and End Date will be the previous month. A previous month may be entered. The report will document workload (RX/Fill Number, Issue Number, Order Number, as applicable, type, and date of the occurrence) attributed to invalid Requesting MEPRS Codes, inactive MEPRS Codes, and invalid DMIS ID/MEPRS Code matches. Workload appearing on this report has not been counted. Correction/counting can be accomplished via the Correct Workload Data (CWD) option.
- *Medical Expense and Performance Report (MEP)*: This option prints the MEPRS workload report for the specified division and date range. The user may select the detailed report, which displays each workcenter on a separate page, the last page of the report being a cumulative summary. The MEP Report applies workload accounting rules. Alternatively, the user may select just the summary report. This report also includes FCD workload, which may be displayed in the report as a one-line total for each representative division, or may be broken down by MEPRS codes within each division, based on which sort criteria is selected.
- *MEPRS Group Report (MGR)*: This option prints the MEPRS Group report for user-specified "groups" and date range. A group is defined as one or more divisions, with each division having a unique identifying DMIS ID number. The primary division's DMIS ID number of the group also becomes the group's ID number.

The user must have access to ALL divisions within a group to select that group for reporting. The system screens which groups may be selected based on the user's divisional access. If the user has access to all groups within an MTF, they

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may select a group report for the entire MTF by entering ALL at the Select/Deselect Group prompt.

- *Product Activity Report (PAR)*: Use this option to display or print a product activity report. This report displays the quantities of drugs dispensed by the outpatient and inpatient pharmacies over a specified time frame. This report could be used to obtain a listing of the most commonly used drug products that require prepackaging for preparation before dispensing. This report also displays the relative frequency of the quantity dispensed for the time frame specified for outpatient products. There is a delimited version of the PAR available on your server; for additional information, please contact your CHCS site manager. Note that the delimited version contains the National Drug Code (NDC) number, which does not appear in the standard print version.
- *Stock Issue Movement Report (SIM)*: This report provides information on bulk/clinic issues to wards/clinics. This report may be sorted by STOCK ITEM or by WARD/CLINIC LOCATION. The sort by STOCK ITEM gives a listing of the wards/clinics that have been issued each item. This sort provides two types of totals. One total, by item for each location, is the total quantity of the item issued to the ward/clinic. The other is the total quantity of the item issued to all locations. The sort by WARD/CLINIC LOCATION gives a listing of the items each location has been issued. This sort provides one total, by location for each item. This is the total quantity of the item issued to the location.
- **Narcotic System Reports Menu (NRR)**: This menu provides options for generating reports specific to the Narcotic System, tracking such information as medications about to expire, narcotics, issues, inventory, outstanding issues, supply vouchers, and transaction statistics.
 - *Expiring Medication Report (EMR)*
 - *Inventory Reports (INR)*
 - *Issue Reports (general) (GIR)*
 - *Issue Reports (specific) (SIR)*
 - *Narcotic Movement Report (NMR)*
 - *Outstanding Issue Report (OIR)*
 - *Supply Voucher Reports (SVR)*
 - *Transaction Reports (general) (GTR)*
 - *Transaction Reports (specific) (STR)*

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- **Outpatient Pharmacy Reports (OPR):** This menu contains options that allow the user to produce various reports specific to outpatient statistics.
 - *DEA Report (DEA):* This report allows the user to print prescription data for all controlled substance prescriptions filled for a specified date range. The user may also specify sort criteria for divisions and outpatient sites within divisions to include in the report.
 - *Hourly Volume Report (HVR):* The Hourly Volume Report allows the user to request a report within a specified date range. The report is broken down by hourly volumes for processing prescriptions. This report could be used to gather statistical data to determine peak work hours for staffing.
 - *Non-Compliance Report (NCR):* Use this option to display or print reports showing non-compliant information for all patients who fail to pick up their prescriptions within an MTF-defined period, but only if the automated non-compliance process is active. The user may specify which divisions and outpatient sites they want included in the report. The user may define the display output as either a report or individual formatted record.
 - *Outpatient Cost Reports (OCR):* This menu allows a comparison of prescription fill cost between local cost and Pharmacy Data Transaction Service (PDTs) cost.
 - *Outpatient Summary Report (OSU):* Use this option to display or print a summary of all prescriptions that were filled and refilled for a specified date range. The user may specify which divisions and outpatient sites to include in the report.
 - *Patient Profile Report (PPR):* This option allows the user to display or print a report showing patient prescription information (profiles) for a selected patient or group of patients. The user may specify sort criteria for divisions and outpatient sites within divisions to include in the report.
 - *PDTs Unavailability Report (UNR):* The report will include any prescriptions that generated an Unavailable label within Pharmacy.
 - *Pharmacy Patient ID Missing Report/Processing (PMI):* This option allows the user to generate a report by date range of all patients who received prescriptions, but do not currently have a patient ID in the Patient file. The user may also elect to initiate a DEERS check on the compiled report before it is printed. Only those patients that did not have a successful DEERS check will appear on the report.
 - *Prescriptions in Suspense Report (PSR):* Creates a report of all prescriptions that would batch if a user chose to batch all. The sort is done by a Massachusetts General Hospital Utility Multi-Programming (MUMPS) routine, but the print is done via the PSO RECORDS IN SUSPENSE print template in the Prescription file.
 - *TMOP Report Menu (TMO)*

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- *VA CMOP Reports Menu (CMR)*: To assist with the management of the VA CMOP interface.
- *Volume Summary Report (VSR)*: Use this option to display on the screen or to print on paper statistical information pertaining to actions on prescription processing. The user can request either an abbreviated or full output format; however, this report does not generate accountable workload numbers. For accountable workload information, consult the “MEP Report.”
- **Spooler Menu (SPM)**: This menu contains options for printing and deleting spooled reports.
 - *Print Spooled Report (PSR)*: Prints reports that have been queued to the spooler.
 - *Delete Spooled Report (DSR)*: Deletes reports that have been queued to the spooler.

PEC/POC Reports

The Pharmacoeconomic Center (PEC)/Pharmacy Operations Center (POC) is a resource available to run PDTS Report Templates that assist pharmacy staff in monitoring Navy Pharmacy workflow data. Pharmacy staff with valid access to the PDTS Business Objects may download the PDTS Report Templates from the Corporate Documents folder of Business Objects.

Pharmacy staff can contact the Pharmacy Operations Center Data Management Team at PEC@amedd.army.mil with any questions, concerns or issues regarding the PDTS Report Templates listed below or any additional requests.

Available PDTS Report Templates include, but are not limited to, the following:

- **Antibiotic Use by AHFS**: This template allows the user to monitor oral antibiotic drug utilization within an MTF. The template runs two reports on the specific MTF, the first report provides the total number of all new prescriptions filled and the number of unique users for the MTF, and the second report provides a list of all new prescriptions for oral antibiotics prescribed during the defined reporting period and organized by American Hospital Formulary Service (AHFS) code.
- **Catchment Area Drug Use Report**: This template allows the user to monitor drug utilizations from Retail and Mail Order for an identified catchment area. The report is based on the site's DMIS ID code and provides information on the drugs dispensed by Retail Network pharmacists located within the catchment area as well as drugs dispensed by Mail Order pharmacies to patients within the catchment area.
- **Corporate Report by DMIS ID**: This template allows the user to monitor prescription workload and expenditures for three points of service within an identified catchment area: MTF, Retail and Mail Order. The report is based on the sites DMIS ID, and divides the data into patients of “All Ages,” “Under Age 65,” and “Age 65+”.

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Drugs Dispensed by MTF Report: This template allows the user to monitor the types of drugs dispensed from a particular point of service over an identified period of time. The report ranks the drug usage by prescription count and dollar expenditure.

- **Drugs Dispensed by PoS Report:** This template allows the user to monitor the types of drugs dispensed from a particular point of service over an identified period of time. This report presents combined data from MTF, Retail and Mail Order points of service, and ranks the drug usage by prescription count and dollar expenditure.
- **Drug Use by GC3 Code and DMIS ID:** This template allows the user to monitor drug utilization by First Data Bank's GC3 therapeutic class codes. The report presents data on specific therapeutic drug classes, as pulled from an identified MTF catchment area (DMIS ID). For catchment areas containing more than one MTF, the report will list the GC3 utilization data separately for each MTF.
- **DUR Edits and Level 1 DDI by MTF Report:** This template allows the user to monitor ProDUR (Prospective Drug Utilization Review) warning messages, via three different reports. The first displays a summary of all ProDUR warning messages reported by PDTs during the report period. The second and third reports emphasize the Level 1 Drug-Drug Interactions (DDI), displayed by dispensing site, pharmacy and medications involved.
- **Header Info:** This template is not designed to run a report, but instead provides a mean to obtain specific header information, for presentation at the beginning of a self-built report.
- **Level 1 DDI Transaction Details by MTF Report:** This template allows the user to view the specific details of each prescription involved in an overridden Level 1 Drug-Drug Interaction (DDI) warning during a specific period of time, and can be used to monitor Level 1 DDIs.
- **MTF Drug Usage:** This template allows the user to monitor the drugs dispensed by a specific MTF during an identified period of time. The report displays the data in two ways, by the prescription count listing, from greatest to least, and by the total submitted amount due, by greatest to least.
- **OTSG Polypharmacy Report:** This report allows the user to identify patients who meet the U.S. Army's Office of the Surgeon General (OTSG) Polypharmacy criteria. This report can identify the patient population through a roster provided by the user, containing the patients' SSN or DEERS IDs, or through the TMA Pharmacy Operations Center (POC) which identifies patients by current facility enrollment data.
 - Note: Use of a patient roster is the preferred method of patient population identification; the TMA POC enrollment data may be misleading due to infrequent data updates.

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- Note: Per the OTSG/MEDCOM Policy Memo 10-076, polypharmacy is defined as a patient who has received four or more medications, which include one or more psychotropic agents and/or one or more central nervous system depressant (CNSD) agents within the preceding 30 days.
- **Patient Profile by DEERS ID:** This template provides a patient profile that contains drug information over a greater period of time than what is available through the CHCS patient profile. The report provides data for each active prescription in the patient profile over a specific period of time (identified with a given start and end date) and is based on the patient's DEERS ID.
- **Patient Profile by SSN:** The template provides a patient profile that contains drug information over a greater period of time than what is available through the CHCS patient profile. The report provides data for each active prescription in the patient profile over a specific period of time (identified with a given start and end date) and is based on the patient's SSN.
- **Provider Profile Report:** The template displays a provider profile, through which the user can review all medications filled, as associated with a provider ID number over a specific period of time. The report displays medications filled by a specific provider, regardless of the point of service used by the patient.
- **Top 10 AHFS Classes by PoS:** This report allows the user to view medications dispensed at a specific point of service, over a defined period of time, as organized by AHFS therapeutic class. The report provides the data in two formats, by prescription count and by total submitted amount due.
 - Note: This template excludes compounded prescriptions, to avoid misrepresentation of data within the therapeutic classes.
- **Top 10 GC3 Classes by PoS:** This report allows the user to view medications dispensed at a specific point of service, over a defined period of time, as organized by First Data Bank's GC3 therapeutic class. The report provides the data in two formats, by prescription count and by total submitted amount due.
 - Note: This template excludes compounded prescriptions, to avoid misrepresentation of data within the therapeutic classes.
- **Top 200 Drugs by PoS:** This report allows the user to view medications dispensed at a specific point of service, over a defined period of time, ranked by prescription count and total submitted amount due.
 - Note: This template excludes prescriptions for Medical Supplies.

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Appendix I – Navy Pharmacy SOP Change Request Form



Navy Pharmacy SOP Change Request



Thank you for submitting an SOP change request. Please fill out this form in its entirety and return to the BUMED Pharmacy SOP Mailbox (BUMED.PharmacySOP@med.navy.mil). Complete a new form per request. The form will be reviewed by pharmacy leadership and you will be notified of a decision.

Please find additional information on the [Navy Pharmacy SOP NKO](#) website:

Requestor:

Job Title:

Rank (If Applicable):

Phone # (For Change Request Follow-up):

Email Address (For Change Request Follow-up):

MTF/Pharmacy Name:

SOP Local Champion:

Section of SOP:

Critical Duty of SOP/Page Number:

Suggested SOP Change:

Reason for SOP Change:

Proposed SOP Language: