UCONN HEALTH
UConn Health
John Dempsey Hospital

(Patient Identification)

PHARMACY CONSULT: ASSESSING PATIENTS ON ANTIRETROVIRALS

THIS TWO-PAGE FORM SHALL BE KEPT WITH PUP SHEET OF THE PATIENT'S LOCATION UNTIL DISCHARGE. ONCE COMPLETED UPON DISCHARGE, FORM IS GIVEN TO THE PHARMACY CLINICAL COORDINATOR.

	Drug	Dose	Directions
Patient's Inpatient Antiretroviral Medication Regimen at Admission			

Pharmacist Validation upon Admission Checklist

☐ Reviewed current home medication list in LCR
☐ Reviewed any relevant ambulatory clinic or emergency room notes in LCR for medication history
☐ Reviewed the patient's prior MARs if admitted from an outpatient or inpatient healthcare facility and data transferred with patient to UCHC

Comments

Completed by:
Pharmacist: Print Name_____ Signature_____ Date_____

Day Shift Decentralized Pharmacist upon Admission Assessment Checklist

☐ **YES** ☐ **NO** ☐ **N/A** Consulted the patient to review their current home medication list
Explanation if answer is NO or N/A (e.g. patient intubated): _____
☐ **YES** ☐ **NO** ☐ **N/A** Reviewed Prescription History in LCR or called the patient's pharmacy, primary provider or caregiver to verify the home medication list. Pharmacy Information: _____
Explanation if answer is NO or N/A: _____

REGIMEN ASSESSMENT
IF ANY OF THE BELOW QUESTIONS ARE ANSWERED NO, CONTACT THE PROVIDER FOR FOLLOW-UP
USE ANTIRETROVIRAL REFERENCES ON PHARMACY WEBSITE

☐ **YES** ☐ **NO** Patient receiving three or more antiretroviral medications
☐ **YES** ☐ **NO** Antiretrovirals are appropriated dosed for renal and hepatic impairment
☐ **YES** ☐ **NO** Antiretrovirals are appropriately scheduled
☐ **YES** ☐ **NO** ☐ **N/A** Dose and schedule of protease inhibitor is appropriate if on ritonavir boosting
☐ **YES** ☐ **NO** Appropriate antiretroviral formulation used
☐ **YES** ☐ **NO** ☐ **N/A** Didanosine and tenofovir are not ordered together as part of the regimen
☐ **YES** ☐ **NO** ☐ **N/A** Amprenavir or fosamprenavir or darunavir is not given to patient with sulfa allergy unless clearly documented that patient tolerates
☐ **YES** ☐ **NO** ☐ **N/A** If CD4+ cell count <200 cells/mm3 (if lab results available), patient is on trimethoprim-sulfamethoxazole, dapsone, or atovaquone
☐ **YES** ☐ **NO** ☐ **N/A** If CD4+ cell count <50 cells/mm3 (if lab results available), patient is on azithromycin

☐ **YES** ☐ **NO** Need to contact provider(s)

DRUG INTERACTION & CONTRAINDICATED MEDICATION ASSESSMENT
USE ANTIRETROVIRAL REFERENCES ON PHARMACY WEBSITE.
PLEASE ATTACH DRUG INTERACTION INFORMATION TO THIS FORM FROM http://www.hiv-druginteractions.org/

☐ **YES** ☐ **NO** Patient is not on medications that are contraindicated with antiretroviral therapy.
If **NO**, contacted provider (s): ☐ **YES** ☐ **NO** (Explain:_____) ☐ **N/A** (Explain:_____)
☐ **YES** ☐ **NO** There are no significant interactions between the patient's medications and the antiretroviral therapy
If **NO**, There are significant interactions, but all medications have been properly dose-adjusted ☐
Contacted provider if significant interaction: ☐ **YES** ☐ **NO** (Explain:_____) ☐ **N/A** (Explain:_____)

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☐ **YES** ☐ **NO** ☐ **N/A** Advised inpatient provider to consider to order an Infectious Disease Consult
Explanation if answer is NO or N/A: _____

☐ **YES** ☐ **NO** ☐ **N/A** Updated home medication list in LCR (notify inpatient provider if done)

Comments	

Assessment completed by:
Pharmacist: Print Name_____ Signature_____ Date_____

Decentralized Pharmacist Daily Regimen Assessment During Admission

If no intervention required by a Pharmacist date and initial below

Date													
RPh Initials													
Date													
RPh Initials													

For any Antiretroviral medication changes, indicate below

Date			
Medication			
Initials of pharmacist that reviewed for appropriateness			
Intervention required and contacted provider(s)	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
Comments			

For any Antiretroviral drug interactions (including additions or deletions of concomitant medication), indicate below

Date			
Medication(s)			
Initials of pharmacist that reviewed for appropriateness			
Intervention required and contacted provider(s)	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
Comments			

Decentralized Pharmacist Discharge Checklist

☐ Reviewed discharge medication list with provider(s) and nurse(s)

☐ **YES** ☐ **NO** ☐ **N/A** Intervention required to adjust discharge medication list based on inpatient medication orders

☐ Reviewed discharge medication list with patient

☐ Conducted medication education with patient using software such as Meducation ® or Lexicomp ®

Comments	

Completed by:
Pharmacist: Print Name_____ Signature_____ Date_____