

HB

51

ALASKA STATE LEGISLATURE

Chair
FISHERIES

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EDUCATION

Member
HEALTH, EDUCATION AND SOCIAL SERVICES

Member
STATE AFFAIRS



REPRESENTATIVE PAUL SEATON
House District 35

Session:
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Juneau, Alaska 99801
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Rep.Paul.Seaton@legis.state.ak.us

Interim:
345 W. Sterling Highway
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Homer, Alaska 99603
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MEMORANDUM

TO: Representative Peggy Wilson, Chair
House HESS Committee

FM: Representative Paul Seaton

DATE: January 28, 2003

RE: Committee Hearing for HB 51

A handwritten signature in cursive script that reads "Paul".

At your earliest convenience could you please schedule House Bill 51 for a committee hearing. Attached you will find a copy of the bill and a sponsor statement. If you have any questions please feel free to call me anytime or speak with my lead staff, Chris Knight at ext. 6867



Alaska State Legislature

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REPRESENTATIVE Paul Seaton

District 35

Sponsor Statement

HB 51

“An act requiring pharmacists to include generic drug information on containers in which brand-name prescriptions drug orders are dispensed.”

As medical technology advances, many senior citizens are taking many different prescription medications to live a longer, healthier life. Seniors receive prescriptions from many different sources, AARP, internet pharmacies, mail order, insurance companies and through local pharmacies as well. Increased availability suggests that drug takers may be taking multiple prescriptions of the same drug, which may be sold under a brand or the generic name. Double dosing may cause severe over-medication leading to serious side effects or even be life-threatening. House Bill 51 was introduced to safeguard Alaskans from overdosing on the same prescription medication.

HB 51 requires pharmacists to include the generic drug name on containers in which a brand-name prescription drug is dispensed. Under this bill, if a person receives a prescription for drug X, then the generic equivalent would also be listed allowing consumers to identify duplicate medications.

One recent story coming out of the Kenai Peninsula involves a woman with Parkinson's disease. The woman placed an order with her insurance company for a particular drug, which they shipped in the generic form arriving about ten days later. In the meantime, the woman went to her local pharmacy and refilled her brand name prescription. Weeks later, her family became increasingly worried when the woman began hallucinating. The family and her doctor were concerned after learning that the woman was double dosing on the same drug.

To safeguard all Alaskans from over-dosing on redundant medications, HB 51 simply requires additional generic labeling on brand name prescriptions.

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REPRESENTATIVE Paul Seaton

District 35

Sectional Analysis

HB 51

“An act requiring pharmacists to include generic drug information on containers in which brand-name prescriptions drug orders are dispensed.”

Section 1. Amends **section 08.80.294** of the state statute requiring a pharmacy to list a generic drug equivalent, when the same pharmacy dispenses brand-name prescription drug order.

(b) States that the information required in **Section 1** (above) shall be placed directly on the container's label.



Honorable Peggy Wilson, Chair
House Health, Education and Social Services Committee
Alaska Capitol, Room 104
Juneau, AK 99801-1182

RE: HB 51 (Seaton) – Support

Dear Chair Wilson:

On behalf of the members of AARP in Alaska, we urge you and your colleagues on the House Health, Education and Social Services Committee to support HB 51, authored by Representative Paul Seaton and co-sponsored by twenty-three House colleagues, including your Committee members Co-Chair Gatto, and Representatives Heinze, Wolf, and Cissna.

AARP believes that anything a state can do to ease the confusion of a consumer taking medication is well worth-while. We understand that Representative Seaton has developed this bill due to a real problem faced by one of his older constituents. We can assure you that many older consumers will benefit from having the generic equivalent name added to a brand name prescription. Helpful and "user-friendly" information will be beneficial for both older patients and younger family members who may be assisting them with their medications.

Representative Seaton's bill will be a welcome addition to quality health care in Alaska.

AARP recommends an "AYE" vote on HB 51.

Should you have any questions about our position, please feel free to contact Marie Darlin (586-3637), Coordinator of the AARP Capitol City Task Force; Patrick Luby (907-762-3314), AARP Legislative Representative; or me (907-245-5259).

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Marguerite Stetson".

Marguerite Stetson
Executive Council Member for Advocacy

Vice-Chair Carl Gatto
Representative Cheryl Heinze
Representative Paul Seaton
Representative Kelly Wolf
Representative Sharon Cissna
Representative Mary Kapsner

Marie Darlin, AARP Capitol City Task Force
Pat Luby, AARP Legislative Representative

02/11/03

To whom it may concern,

Thank you for asking my opinion on this important piece of legislation, House Bill no. 51.

As you know all drugs have generic names and many of them have brand names as well. Many states have, for years, required generic labels on prescriptions since generic labeling is the standard of practice for uniformity and accuracy both medically and scientifically. Unfortunately this not always harpening in Alaska for dispensed prescriptions.

I have seen a number of occasions in my own practice where people have mistakenly taken duplicate prescription medications because of these variations in labeling. These have sometimes led to drug intoxication requiring hospitalization. Even then the problem has not been immediately noticed. This unnecessary suffering and cost from drug misadventure can be prevented.

In my opinion I think your wording would be clearer and more concise with changes as written below:

“An Act requiring Pharmacists to label prescription drug containers with generic drug information.”

“In addition to other information that may be required under state or federal laws or regulations, the Pharmacist, when dispensing a prescription drug order, shall label using the generic drug name. If the prescriber wishes- such as when brand name is medically indicated, or the patient requests it, the brand name may also be included in parentheses.”

I would avoid stipulating exactly where to put labeling since regulations already address this and computer labeling systems have only so many options.

I hope it is obvious that I strongly support generic drug labeling as a matter of education and safety.

The State Board of Pharmacy may also have an opinion on this matter.

Respectfully submitted,

A handwritten signature in cursive script that reads "R P Albertson". The signature is written in dark ink and is positioned above the printed name.

R. P. Albertson RPh, CS, CGP, FASCP

February 3, 2003

Honorable Representative Paul Seaton
State Capital, Room 428
Juneau, Alaska 99801-1182

Dear Representative Seaton:

Please accept this letter in support of HB 51 relating to including generic drug information on containers in which brand name prescription drug orders are dispensed. Homer Senior Citizens, Inc. supports this legislation because it would help to eliminate the possibility of an individual taking a double dose of medication. This legislation is particularly important for seniors and caregivers that take care of seniors.

At the present time, because prescriptions are sometimes written using the generic name and sometimes using the brand name, it is possible for an individual to have two bottles of medication with different names on them, which are in fact the same. Because both labels will indicate a dosage such as one pill three times a day, it is very possible for the individual to take a double dose. This is particularly true if the individual is a senior who has some dementia or the individual is being helped by a caregiver that is not totally familiar with the medications and is only reading the dosage levels.

One might ask how an individual could have two prescriptions for the same medication with different names at the same time. What may happen is that a doctor prescribes a medication for an individual to be purchased from a mail in pharmacy. These usually are generic drugs because the mail in pharmacy is usually associated with a medical insurance plan. At some point, a prescription may not arrive and the individual asks the doctor to write a prescription to a local pharmacy to get them by until the other prescription arrives. This prescription may be written for a brand name. Thus the individual now has two bottles of the same drug with different names. This same scenario could also occur between two local pharmacies if the doctor used the generic name for the first pharmacy and for the next used the brand name.

In any case, this legislation would help to eliminate the possible confusion that an individual or caregiver may have and thus a possible overdose. If we can provide additional information, please contact us.

Sincerely,

Fred Lau
Administrator
Homer Senior Citizens, Inc.



Representative Paul Seaton
Alaska State Legislature
Pouch V
Juneau, Alaska 99801

Dear Representative Seaton:

This is a letter in support of House Bill 51 "An Act requiring pharmacists to include generic drug information on containers in which brand-name prescription drug orders are dispensed".

The bill should achieve two important benefits.

The first is to avoid confusion by patients inadvertently taking dual dosages of medication because they do not equate a brand name drug with a generic equivalent.

The second may be increased recognition by consumers that there are generic drug equivalents available for many brand name drugs that are equally effective but less expensive than the brand name drugs. The increasing cost of drugs is one of the leading drivers of health insurance costs. Many health benefit plans have provisions which encourage use of generic drugs in order to reduce the cost of health insurance.

Thank you.

Sincerely,

Jeff Beck
by (PJI)

Jeff Beck

Aetna

Subject: HB 51 Follow-up

Date: Fri, 24 Jan 2003 17:27:36 -0500

From: "Laubacher, Cynthia" <Cynthia_Laubacher@medcohealth.com>

To: "rep.paul.seaton@legis.state.ak.us" <rep.paul.seaton@legis.state.ak.us>

Representative Seaton: Thank you for your call. I apologize for the e-mail, but the (800) number won't work for out of state callers, and I can't seem to access the state website for your office number.

I spoke with my folks in headquarters and explained your goal. They re-thought their initial comments and have no concerns with the proposal as it is written.

On a side note, I looked up your bio and learned that we have something in common - we were both raised in Oxnard! I graduated from Santa Clara High - a long-time football rival of Hueneme. I am always pleased and surprised to meet someone from my hometown. I hope we have the chance to meet if I get a chance to make it up to Alaska!

In the meantime, please feel free to contact me if I can ever be of assistance. Best of luck with HB 51. Have a wonderful weekend!

Cindy

Cynthia M. Laubacher

Director, State Government Affairs

Medco Health Solutions, Inc.

916-726-1081

916-726-9756 - fax

Legislative Research Services

Alaska State Legislature
Legislative Affairs Agency
Division of Legal and Research Services

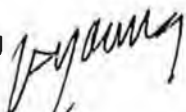
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January 17, 2003

Memorandum

TO: Representative-elect Paul Seaton

FROM: Patricia Young
Manager



RE: Reducing Prescription Drug Errors

You asked for background information that we could quickly gather on problems encountered by the elderly in using prescription drugs. You were particularly interested in information on efforts to deal with such problems.

As you'll see from the attached materials, the Institute for Safe Medicine Practices (ISMP) is a good source of information on all aspects of your question.¹ The organization publishes "Safe Medicine," a newsletter that among other things, always prints generic names of medications in *red*. In contrast, they capitalize specific brand names and print them in *green*. They follow specific brand names with the generic name in parentheses. We've provided several documents from the institute website, including testimony before the U.S. Ways and Means Committee that includes some specific recommendations in regard to reducing prescription errors, misuse, and adverse events.

We've also included information from the National Institute on Aging (NIA) and the Food and Drug Administration (FDA). The National Association of Boards of Pharmacy (www.nabp.net) and the Administration on Aging (www.aoa.gov/elderpage.html) are good resources as well.

During our quick search we encountered a number of references to "Brown Bag" medicine check programs through which pharmacists, nurses, or doctors assess seniors' collections of medications for compatibility, expiration dates, etc. We include a description of one such program. We also include information on a National Association of Boards of Pharmacy study commissioned by the FDA to assess the extent and usefulness of the private sector prescription information that patients receive along with their medications.²

Lastly, we include a printout of "Recommended Best Practices—Medication Errors," published by the Tennessee Department of Health, and adopted by Tennessee Improving Patient Safety (TIPS). Under "15 Ways to Lower your Dose of Medication Errors," we found the following statement and guidelines:

A study from the University of Chicago Medical Center places the incidence of medication errors between 1.7 and 59.1 percent. According to the Joint Commission on Accreditation of Healthcare Organizations, 15 percent of reported medication errors are due to confusion

¹ The Institute for Safe Medication Practices website address is www.ismp.org.

² The results of that study, published in 2001, can be found at <http://www.fda.gov/cder/reports/prescriptioninfo/default.htm>.

U.S. Food and Drug Administration

Department of Health and Human Services
Food and Drug Administration
5600 Fishers Lane (HF1-40)
Rockville, MD 20857
February 2000
(FDA) 00-3237



Medicines and Older Adults

The Food and Drug Administration, or FDA, is a United States government agency that makes sure medicines are safe and accurately labeled.

Be More Careful With Medicines

While everyone needs to be careful about taking medicines, older adults need to be even more careful. This is because:

- Older people often take more medicines than younger people
- Older people may react differently to medicine. T

This brochure will tell you what older adults need to know about the medicines they take.

Problems

Two of the biggest problems older people have with medicines are:

- Reactions from mixing two or more drugs in the body, called "drug interactions." A drug interaction can cause bad effects (usually called side effects), such as a rash, stomach upset or sleepiness.
- Getting too much of one medicine, called "drug overdose." This, too, can cause side effects.

Older people are more likely to have side effects from drug interactions or drug overdoses because:

- They are more likely to take a number of different drugs.
- Their bodies use food and drugs slowly. This means that it may take longer for a drug to start working. Drugs also may stay in their bodies longer. This can cause too much of the medicine to be in the body.

Common side effects of drugs are:

- upset stomach, such as diarrhea or constipation
- blurred vision
- dizziness
- mood changes
- skin rash

"Start low and go slow" is good advice for older people when taking medicines. This means

- What does the drug do?
- When should I take the drug? How often?
- Does it matter if I take it with food?
- Are there any foods I should stop eating while I'm on this drug?
- Is it safe to drink alcohol, such as beer or wine, while I'm on this drug?
- How long will I need to take this drug?
- What should I do if I forget to take the medicine?
- What are common side effects?
- How will I know if this drug is working?
- Where should I keep this drug?

How to Save Money on Medicines

- When trying a drug for the first time, ask your doctor for free samples. Or ask the pharmacist for just a few pills before getting the whole prescription filled. That way, you can see if you have problems with the medicine before paying for a whole bottle.
- For drugs you take all the time, buy larger amounts at a time so that the price for each pill is cheaper. But before you do this make sure you will be able to use all the medicine within at least a year. Holding on to medicines for a long time may cause the drug to lose its ability to work.
- Call around to see which store has the lowest price.
- If you are an older person ask about a senior citizen's discount.
- Ask your doctor if it's OK to take a generic drug instead of the brand-name drug. If it is OK, tell the pharmacist you want the generic version of the medicine.
- For drugs bought over the counter, buy the store-brand or discount brand. The pharmacist can help you choose.
- Call or write to the local chapter of the American Association for Retired Persons (AARP) or a local chapter of a health organization, such as the American Diabetes Association or the American Heart Association. You may be able to buy drugs through them at lower prices.

Do You Have Other Questions About Medicines?

FDA may have an office near you. Look for the number in the blue pages of the phone book.

Or, call FDA's toll-free number, 1-888-INFO-FDA (1-888-463-6332). Or, on the World Wide Web at www.fda.gov.

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FDA/Website Management Staff
Web page created by tg 2001-JAN-22.

Suicides, drug overdoses overtake crashes in deaths ; Lee Filas Daily Herald Staff Writer; ; Chicago Daily Herald (Paddock) ; 11-06-2002 ;

Suicides, drug overdoses overtake crashes in deaths

Byline: Lee Filas Daily Herald Staff Writer

Edition: Lake

Section: NEWS

For the first time since 1997, auto accidents were not the leading cause of unnatural deaths in Lake County, according to a report by the coroner's office.

That dubious distinction in 2001 went to suicides and drug overdoses. Suicides took over the top slot with 44 cases, while drug overdoses - prescription and illegal - ranked second with 41 deaths, the annual report stated.

Deaths investigated in 2001 showed 39 people died as a result of auto accidents, down 26 percent from the 53 recorded in 2000.

Jim Wipper, deputy Lake County coroner, said the decrease in vehicular deaths is something the coroner's office would like to see more of in the future.

"It's definitely the trend we are happiest seeing," Wipper said. "We look at that as one of the most positive trends we've uncovered, and it's something that we have worked hard to decrease."

That improvement was offset by a rise in drug overdoses - up 8 percent from 2000 - and a dramatic increase in homicides over previous years, Wipper said.

The 19 homicides in 2001 more than doubled the 8 recorded in 2000. The number is still less than the 25 murders recorded in 1997, but more than the 15 recorded in 1998.

"That's definitely a concern for us," Wipper said. "It's always a concern when we see a jump in any category, but to see that large of an increase is definitely something we need to look at."

Lake County Board Chairman Suzi Schmidt said the rise in homicides is alarming, but not a complete surprise given the county's growing population.

"Simply stated, the more people we have, the more crime we are going to get," Schmidt said. "Any kind of rise in crime is definitely a concern, be it white collar, homicide or robbery."

Wipper said deaths are labeled as either natural or unnatural by the coroner's office. There were a total of 2,941 deaths recorded in the county in 2001, of which 2,756 involved natural causes.

The remaining 185 are listed in the report as violent - overdoses, homicides, suicides and vehicular deaths - or accidental - drowning, fire and other accidents.

This is the fifth consecutive annual increase in drug overdose deaths in the county.

Wipper said a more readily available supply of cocaine and heroin has contributed to the increase.

"But the No. 1 cause of overdose deaths remains prescription overdoses, like painkillers and such," he said.

Testimony of Michael R. Cohen, MS, RPh

President, Institute for Safe Medication Practices

Testimony Before the Committee on Ways and Means

Subcommittee on Health, Congress of the United States

LEGISLATIVE RESEARCH
SERVICES

House of Representatives

Hearing on

Medicare Reform: Laying the Groundwork for a Prescription Drug Benefit

March 27, 2001

Good afternoon. Madame Chairman and Members of the Committee, thank you for the opportunity to speak with you this afternoon about important health care quality issues related to the design of a prescription drug benefit program for Medicare beneficiaries. I am Michael R. Cohen, a pharmacist and president of the Institute for Safe Medication Practices (ISMP). ISMP is an independent, nonprofit organization that works closely with practitioners, regulatory agencies, health care institutions, professional organizations and the pharmaceutical industry to provide education about adverse drug events and their prevention. A board of trustees representing the health care community at large governs this interdisciplinary effort by nurses, pharmacists, physicians and health care consumers. Our primary focus has been on proper and safe use of medications. We have a long history of learning about medication errors from health care practitioners and consumers who voluntarily report medication errors and hazardous conditions through a national reporting program operated by the United States Pharmacopeia. All reports are shared directly with the US Food and Drug Administration, Office of Post-marketing Drug Risk Assessment. Dialog with FDA is ongoing when reports relate to drug nomenclature issues (proprietary and nonproprietary names), or pharmaceutical labeling, packaging and medical device design.

Information about medication errors, other adverse drug events, and recommendations for prevention are shared with the medical community through our web site (www.ismp.org); ongoing columns in 16 professional journals that reach nurses, nurse practitioners, pharmacists, physicians, and physician assistants; and a biweekly publication, *ISMP Medication Safety Alert!* that reaches all US hospitals, and. Currently, we are preparing to launch a similar newsletter for chain and independent community pharmacies. In addition, we reach regulatory authorities and pharmaceutical manufacturers internationally through regular publications in international journals and newsletters. Information from ISMP has been used to effect thousands of improvements in professional practice and commercial drug labeling, packaging and nomenclature. The organization has gained the trust and respect of practitioners and senior officials in health care throughout the nation.

Recommendations to Reduce Error and Improve the Quality of Medication Use

Medications are a blessing, but humans must safely prescribe, prepare, dispense, and administer these drugs. Yet humans are fallible, and as clearly articulated in the recent reports by the Institute of Medicine (IOM), errors and other adverse events occur and cause unbearable

human and financial cost. Medication use has been further complicated by the large number of new drugs and technologies introduced every year, an increasing elderly population with chronic and acute conditions requiring complex treatment strategies, and the proliferation of over-the-counter products. In light of this fact, much can and should be done to enhance medication safety.

The current prescription drug benefit legislation is a strong and appropriate vehicle to drive medication safety. Payers bear responsibility for medication errors when they occur because of insufficient support of basic services and lack of quality/safety requirements. As purchasers of pharmacy services through mail and community pharmacies, payers - including Medicare - should require providers to comply with standards most likely to enhance medication safety. They should offer their beneficiaries some assurance of safe pharmaceutical care, which includes important monitoring of the appropriateness of drug therapy and its effects, not just accurate dispensing.

ISMP has identified several focal points that would be most appropriate for legislation related to prescription drug benefits:

- Continuous quality improvement activities to enhance safety in our nation's pharmacies;
- Better clinical utilization of community pharmacists and pharmacy beneficiaries; and
- Expanded use of effective technology.

Achieving and maintaining standards related to these focal points will likely require resources that are not currently available. Thus, legislation must also include changes in the current reimbursement systems to properly support any required safety enhancements.

Continuous Quality Improvement

Data from the USP-ISMP Medication Error Reporting Program reveals that medication-related problems are repetitive in nature. An incident of misuse in one setting is likely to repeat itself in another. Most importantly, the system changes necessary to prevent errors are similar and a growing body of literature is available to guide these efforts. Tragically, too many organizations and individual providers do not believe similar incidents could happen to them. They fail to use information about errors occurring elsewhere as a roadmap for improvement in their own organization or practice. It is not until a serious error hits home that aggressive prevention efforts are implemented. With so much evidence-based information about error prevention at hand, there is little excuse for reacting to errors after they happen instead of preventing them. We need Congress to help shorten the interval between the lessons taught by errors and the widespread corrective action to prevent future errors.

The development and implementation of continuous quality improvement (CQI) efforts should be the highest priority in all pharmacies. Such efforts must be aimed specifically at preventing well-known and repetitive categories of prescribing and dispensing errors, which erode patient confidence in our health care system. For example, in order to participate in the prescription drug benefit program, pharmacies should be required to seek out medication safety information and use it proactively to prevent medication errors. At the same time, safety issues recognized internally and reported by patients must be documented and analyzed, and a process must be established to determine the best strategies to prevent future problems and ensure its implementation. An annual survey to assess consumer perceptions of the quality of pharmaceutical products and professional services might also be required to supply additional

information upon which to base improvement strategies.

Informational tools like our *ISMP Medication Safety Alert!* publication, or ISMP's *Quarterly Action Agenda*, which is a readily available list of medication problems compiled from our nation's reporting programs, can be a backbone of any CQI effort. The very purpose of the USP-ISMP Medication Error Reporting Program - indeed the purpose of any type of safety reporting program and the expert recommendations that stem from it - is to guide the implementation of quality improvement initiatives by practitioners and organizations. If this is not accomplished, the value of any medical safety-reporting program is diminished. Thus, appropriate funding is needed to ensure that information flowing from error reporting programs are efficiently transformed into learning programs to prevent future errors. Research-based information, anecdotal reports of adverse events, reports from the Joint Commission on Accreditation of Healthcare Organization's Sentinel Event Newsletter, and information from other sources are also instrumental in this effort. ISMP is prepared to assist the Secretary of Health and Human Services, as well as the nation's professional licensing boards, health departments, accreditation agencies, regulatory authorities, and individual organizations in using such informational tools to develop effective CQI strategies that can successfully stop repetitive medical errors.

Practice sites should also be required to conduct self-assessments to help prioritize improvement projects at least annually. In a cooperative project with the American Hospital Association (AHA), ISMP recently developed and distributed the ISMP Medication Safety Self-Assessment to virtually all US hospitals. This weighted self-assessment instrument provides a list of nearly 200 effective medication error reduction strategies in the general hospital setting. Nearly 1,500 hospitals participated fully in the project, which resulted in a large national database of hospital efforts to improve patient safety with medications. This database will allow health care providers to identify areas of weakness and focus improvement activities upon system elements and characteristics that are known to be effective for preventing patient harm. We will also be able to track improvement efforts in the nation's hospitals over time by repeating the process at a later date.

While 1,500 hospitals completed the assessment and sent data to ISMP, there are approximately 6,000 acute care hospitals in the US. Through 1,000 follow-up telephone calls to a randomized list of hospitals, we learned that many more hospitals would have participated had it not been for advice given them by a national risk management organization to seek legal counsel before returning data to us. This letter instilled a renewed fear of discoverability in a future lawsuit, which had a chilling effect on the ability of hospitals to participate in this extremely valuable project. Unless the basic problem - discoverability of information used in quality improvement projects like this one - is addressed by Congress, we will continue to lose valuable opportunities to address costly (both human and financial) patient safety issues. Records of quality improvement activities must be afforded protection under available state peer review or other protective statutes and thus protected from discovery during civil litigation. It should be noted that Governor Gray Davis of California signed legislation last August to require quality improvement activities following written policies and procedures in the state's pharmacies. A process must be in place to detect and analyze medication errors. Importantly, information that is part of the proceedings and records of review are protected from discovery. Texas and Florida also have quality improvement requirements that include the above protective provisions and several other states are now considering them. This should be a nationwide standard.

Recently, the American Pharmaceutical Association Foundation and the National Association of Chain Drug Stores agreed to fund ISMP to independently develop and implement a similar

self-assessment tool for the nation's community pharmacies (chain, independent as well as hospital and clinic ambulatory care pharmacies).

Quality improvement requirements should involve all participants in pharmaceutical care, including claims processors and pharmacy benefit managers. Unfortunately, payment policies actually contribute to error. Underpayment of pharmacists, lack of standards for claims processing, numerous interruptions, and phone calls for prescription reimbursement adjudication and pre-approval have resulted in less time available for drug monitoring and patient education activities. An example is requiring pharmacists to dispense drugs at a dose higher than prescribed and making patients split the tablets. An error-prone process - to decrease the cost of a prescription medication. For example, the manufacturer may similarly price an 80 mg, 40 mg, 20 mg, and 10 mg tablet. Although the physician may prescribe 20 mg tablets to be taken four times a day, the pharmacist is required to dispense the 80 mg tablet and tell the patient to take ¼ tablet four times a day. Some patients may become confused and take the full tablet or inaccurately split the tablet. In many cases, to assure that the patient takes the medication properly, a pharmacist will actually break the tablets into one-quarter size. However, the split tablets may begin to crumble in the prescription vial, leading to inaccurate doses.

I would also underscore the need for Congress to oversee providers and payer activities and that participants agree, as a condition of participation, to periodic visits from appropriate authorities to review documentation of quality improvement activities. Currently, little or no oversight exists from standards organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Medicare Peer Review Organizations, state professional boards, departments of health, etc. Without oversight, the private sector has not solved problems associated with safe medication use.

Surely, continuous quality improvement activities are better for the health care provider and public since it offers the potential for reducing the number of prescription errors. A new study released in the American Pharmaceutical Association's (APhA) March/April Journal of the American Pharmaceutical Association (JAPhA) has updated an analysis of prescription drug use problems in the United States. It estimates that drug misuse costs the economy more than \$177 billion each year. The estimated number of patient deaths has increased from 198,000 in 1995 to 218,000 in 2000. Clearly, we must have required quality improvement activities to reduce this unnecessary burden. In the legislation, the Secretary of Human Health and Services should be directed to form a task force to examine these and other suggestions to formulate quality improvement requirements that would accompany the prescription drug benefit program. Funding for these activities must be assured.

Improved utilization of pharmacists and pharmacy beneficiaries

The value of medications used appropriately is immense. But, if pharmaceutical care involves reimbursement for only dispensing activities, the drug safety problem will only worsen. Worse, we are overlooking one of the nation's most valuable allies in assuring proper drug use. A trip to the local pharmacy often provides clear evidence that many pharmacy graduates, now educated at the doctoral level with advanced clinical training, are sorely underutilized in the fight against costly adverse drug events. Instead of performing clinical functions for which they are well trained - overseeing a competent technical dispensing staff, screening new prescriptions for safety concerns, educating patients on proper drug use, monitoring patients for side effects - many are tied instead to dispensing activities, managing pharmacy benefit plans and drug inventories, and performing clerical tasks. Further, with improving technologies (robotics, bar coding of pharmaceuticals and computerized prescriptions) and increasing numbers of certified

pharmacy technicians (over 80,000 currently), more of the pharmacist's time will be available for clinical functions.

The Institute of Medicine (IOM) Committee on the Quality of Health Care in America, in their most recent report, *Crossing the Quality Chasm: A New Health System for the 21st Century* IOM urges a strong national commitment to improve health care across six broad dimensions of quality: safety, effectiveness, responsiveness to patients, timeliness, efficiency, and equity. The authors suggest that the current health care system is failing to provide safe, high-quality care consistently to all Americans because it is poorly designed and relies on outdated systems. The report envisions a revamped system which is centered on patient needs and preferences, encourages teamwork among health care providers, and makes greater use of evidence-based approaches to care and information technology. The IOM Committee members recognized that, if organizations are expected to change the processes of care, broader environmental changes are also needed. Importantly, examination of current payment methods (e.g., fee for service, capitation, etc.) to remove barriers to innovation and quality, and testing of options to better align payment methods with quality goals. Realigning the payment to recognize pharmacist clinical services fits right into that idea.

To prevent adverse drug reactions, we need better ways to detect problems early. Pharmacists can serve well in this role, also. They could manage the risk of existing technologies by aggressively monitoring the effects of new drugs on the market and identifying the need for special monitoring to prevent serious adverse events. Thus, pharmacists could safely monitor new and useful drugs that might otherwise be removed from the market because they are being prescribed inappropriately. With the new prescription drug benefit program, strong consideration should be given to reimbursing pharmacists for time spent monitoring patients closely to detect and report anticipated or previously unrecognized problems to the FDA. This would result in earlier detection of medication-related problems and their timely resolution.

Further, we should learn from the valuable experience of the HCFA-required drug regimen review process in long term care, which has saved billions of dollars in prescription drug benefits while also protecting residents from preventable adverse drug events. A comprehensive, on site, drug regimen review is conducted initially upon a patient's admission to a facility and reassessed monthly. As part of drug regimen review, the pharmacist evaluates appropriateness and safety of medication orders and verifies documentation. The pharmacist investigates possible adverse drug reactions in residents who exhibit various identified disorders. A current written diagnosis or identified need and relevant diagnostic data must support medication orders. As needed (PRN) medication orders must include specific written indications for use. Medications selected must be consistent with patients' care plans and shall have a favorable benefit-to-cost ratio reflecting consideration of medical history, the significance of any past drug reactions, and cost. When problems arise, the pharmacist makes recommendations (including identification of the concern, specific means to correct the situation and a determination of how and when improvement will be measured) to appropriate personnel. . Consultant pharmacist-conducted drug regimen review improves optimal therapeutic outcomes by 43% and saves \$3.6 billion annually in costs from avoided medication-related problems. (Bootman JL, Harrison DL, Cox E: The health care costs of drug-related morbidity and mortality in nursing facilities. *Arch Int Med* 1997; 157:1531-36. The recommendations must be addressed as a condition of participation.

In the ambulatory care setting, beneficiaries themselves should be required to undergo at least a quarterly review of their prescription and over-the-counter medication regimen by a pharmacist. Similar to the above functions, the requirement would establish that presently prescribed drugs

are necessary, that possible adverse effects are identified and reported to the patient's primary care provider, that the beneficiary is aware of proper storage requirements, dosing schedules, side effects, and so on. Pharmacists would be paid to monitor patients closely to detect problems with new drugs or for suspected problems. Not only would this improve care and vastly reduce the nearly \$200 billion dollar cost of adverse drug events, it would also eliminate the cost of unneeded medications that patients may still be receiving! The savings to Americans would be enormous. We believe that the legislation should not move forward without a provision for this drug monitoring review with logistics determined by the Secretary.

Another important component is improving patient understanding of their important role in safe medication use and error prevention. About 25% of medication errors reported to our program and FDA's MedWatch program stem from confusion between proprietary and nonproprietary names. An educated patient or caregiver can be a crucial last check on the safety of any medication. For example, if patients are aware of the name and purpose of their medication, they are better able to recognize if a pharmacist misread the prescription and dispenses a different medication for an unexpected purpose. Legislation should require that the medication's purpose and full instructions be written on each new prescription so that pharmacists can educate patients properly and prevent errors if the purpose and prescribed drug do not match. Listed indications for the drug will also help patients and pharmacists ensure that their interpretation of the prescription is consistent with the prescriber's intent.

Regrettably, the requirement for patient counseling in OBRA 90 legislation is vastly underutilized. Few patients take advantage of the pharmacist's offer to counsel. Instead, they rush the pharmacist to fill a prescription and may not read accompanying drug information material that could prevent adverse events. The new legislation must address the issue by insisting that patients and caregivers have full explanations of new medications while in the doctor's office or pharmacy.

Further, legislation should facilitate health care practitioners' access to crucial information about the patient. Harvard researchers (Leape LL et al. Systems analysis of adverse drug events. JAMA 1995; 274:35-43) showed that over 40% of adverse drug events can be tied to insufficient information about the patient or drug at the time of prescribing, dispensing and administration of medications. [The most recent IOM report notes that clinicians operate in silos without the benefit of complete information about the patient's conditions, medical history, treatment received in other settings, or medications prescribed by other clinicians. The report encourages cooperation among clinicians to exchange appropriate information and coordinate care.

Indeed, the same researchers (Leape LL et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. JAMA 1999;282:267-270) showed that pharmacists could prevent 66% of adverse drug events if given access to clinical information to screen and adjust doses and suggest other interventions when clinical indicated.

For example, if a physician fails to adjust the dose of a potentially toxic medication that is excreted through the kidneys in a patient with poor renal function, costly hospitalization, dialysis, transplant, or death may result. While renal function and other important clinical information may be residing in hospital or physician office records, it is often inaccessible to community pharmacists. But with better access to clinical information such as laboratory data, chronic diseases, organ function, allergies, and weight, the pharmacist can screen drug orders appropriately and prevent untold numbers of errors, injuries, and associated costs. The use of web sites or "smart cards" where patients could voluntarily maintain confidential clinical information accessible to their health care practitioners could significantly improve access to

information.

Improved use of technology

Health care remains relatively untouched by information technology that has transformed so many other aspects of society. Patient information, including medication prescriptions, is still dispersed on paper, poorly organized, often illegible, and difficult to retrieve. Yet, research shows (Bates DW et al. Effect of computerized physician order entry and a team intervention on prevention of serious medication errors. *JAMA* 1998;280:1311-16) that over half of all medication errors can be prevented through computerization physician order entry (CPOE). An ISMP survey (*ISMP Medication Safety Alert!* February 10, 1999 - www.ismp.org) of our nation's computer systems shows that fewer than 13% of US hospitals even have the capability for CPOE. Even fewer ambulatory care physicians are using electronic prescribing technology (estimated to be under 5%). Nevertheless, our survey shows that most in-use prescribing software today does not alert users to errors in an accurate and efficient manner. System vendors and organizations must jointly accept responsibility for designing and implementing systems that offer clinical support to providers and warn about potentially unsafe prescriptions.

Most of the technology software problems stem from the lack of interface and compatibility standards to allow stand alone systems to be fully integrated with each other to ensure that appropriate patient and drug information is available to providers. For example, standards are needed to ensure that any physician can send a prescription to any pharmacy electronically. This eliminates the risk of misinterpreting a handwritten prescription while increasing the detection of potential adverse drug events. We also need to address regulatory and legal barriers that prevent use of electronic prescribing. For example, in many states, verified electronic signatures are not acceptable, thus prescribers must physically sign each prescription. Further, incentives should be provided to reward health care practitioners and organizations that adopt technology known to reduce medication errors, such as electronic prescribing and bar code technology.

Bar coding technology can greatly enhance the accuracy of drug dispensing and administration. Although the use of such technology is expanding in ambulatory care pharmacies, mainly through robotics, the pharmaceutical industry must join in this effort by assuring that all drug packages have a standardized, readable bar code or other machine-readable code.

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Be an informed consumer

Unfortunately, medication errors happen. They happen in hospitals, in pharmacies, or even at home. And sometimes people get hurt because of these errors.

The more information you have, the better able you are to prevent errors and to take care of yourself. You have to ask your pharmacists, doctors and nurses about your medications, and you have to expect answers.

Also, if you have any chronic illnesses, pick up one of the consumer guides about medications at a bookstore or from the library. Find out all that you can about your illnesses and the medications you are taking. What you learn will help protect you later.

Your doctors, nurses and pharmacists work hard to keep you healthy, but you are also responsible. Learn what questions to ask. Expect answers--it's your life and your health!

Key Questions

Your pharmacist can be your partner to prevent medication errors. Find one who offers services like monitoring your therapy and keeping a complete list in the pharmacy computer of all your medications and chronic medical conditions. Include over-the-counter medications, vitamins, nutritional supplements and herbal products even if you bought them somewhere else. It's worth the cost. With this information in one place, your pharmacist can help to protect you against harmful drug interactions, duplicate medications and other potential problems.

Before you leave the pharmacy, your pharmacist should give you printed information about the medication and make sure that you understand the answers to these questions:

1. What are the brand and generic names of the medications?
2. What does it look like?
3. Why am I taking it?
4. How much should I take, and how often?
5. When is the best time to take it?
6. How long will I need to take it?
7. What side effects should I expect, and what should I do if they happen?
8. What should I do if I miss a dose?
9. Does this interact with my other medications or any foods?
10. Does this replace anything else I was taking?
11. Where and how do I store it?

When you buy over-the-counter

States setting up nonprofit prescription operation

DRUGS: Plan intended for millions of state employees, Medicaid recipients.

By **MILY FREUDENHEIM**
The New York Times

In the strongest challenge yet in the battle between states and manufacturers and distributors of prescription drugs, nine states and the District of Columbia are organizing a joint, nonprofit operation to manage their prescription plans, officials in charge of the effort said.

The states intend to hold down spending on medicines for millions of state employees and Medicaid beneficiaries by creating an organization designed to be immune to drug makers' promotions of many of their more expensive products.

The new organization is being formed at a time when two-thirds of the states are reducing Medicaid coverage, restricting eligibility or ending benefits altogether for at least 1 million people. A study by the Kaiser Family Foundation said that state Medicaid directors expect further

cuts in benefits and eligibility.

Dozens of states are facing their largest deficits in years. Their combined shortfall for the current fiscal year is estimated at \$45 billion, with some state deficits reaching 20 percent.

Health care spending is a major part of the financial problems the states face, and drugs are the fastest growing component.

New York, for example, spent \$2.4 billion on prescription drugs for more than 3 million Medicaid recipients in 2001, 7.5 percent of all its Medicaid

spending and an increase of 75 percent from 1998.

"New York has the most to gain," from the new organization, said Peter E. Shumlin, chairman of the National Legislative Association on Prescription Drug Prices, the group that is organizing the new benefit plan. Shumlin said New York "is doing the least of all the states" in his group to hold down drug spending.

The new drug benefit manager will try to help New York, Maine, Massachusetts, Connecticut, Rhode Island, Vermont, New Hampshire,

Pennsylvania and Hawaii maximize the drug benefits they can provide given their current budget constraints.

Drug benefits for the state employees and Medicaid recipients in most of these states are currently managed by private companies called pharmacy benefit managers. These drug plan managers collect sizable rebates from drug makers in return for promoting certain drugs. They then create lists of drugs for different ailments and often set prices that encourage drug plan members to opt for the drugs that have been promoted.

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ISMP **MEDICATION SAFETY ALERT!**



Request a Brown-Bag Check-up

If you have a chronic condition, you may routinely take many different kinds of medications. Often, the dose or times of the medication may need to be adjusted as your health changes. Sometimes, you may also have medications ordered by different doctors, particularly if you visit a number of specialists. These situations can lead to a great deal of confusion when taking medications. As a safety measure, ask to schedule a "brown-bag check-up" with your primary doctor or local pharmacist. A brown-bag check-up is when you gather all of your current medications and over-the-counter products into a "brown-bag" and show them to your doctor or pharmacist so he/she can look for any potential problems.

Schedule your brown-bag appointment in advance so the doctor or pharmacist has allotted enough time for the visit. Remember to take any prescription medications, over-the-counter medications, herbal products or "natural products" you are using.

During the "check-up", the doctor or pharmacist will review all of the medications and products you are currently taking, to see if they are the same as those listed on your medical record or pharmacy profile. They can double check these medications for the correct dosage strength, frequency, or identify if you are using outdated or discontinued medications. These practitioners can also screen the medications and products for potential duplication of therapy or side effects. This is why it is important to include non-prescription products in the bag.

A brown-bag check-up is not only helpful to patients, but is useful for physicians and pharmacists too. This review will help healthcare practitioners know whether you understand how to take the medication, or if you are aware of any special precautions that you may need to know about. This is also a good time for the doctor to discuss with you any special laboratory testing that may be needed with certain drugs. You should be prepared to ask any questions you may have about your medications. Don't be afraid to write them down, so that you do not forget to ask.

Having a single doctor "in charge" or aware of all of the medications and products that you take, is a safe rule. If this is impossible, keep your list

FAMILY PHARMACY
11432 BUSINESS BLVD
EAGLE RIVER, AK 99577
907-694-7007

***** PATIENT INFORMATION LEAFLET *****

DATE: February 12, 2003

PATIENT: JOHN DOE

RX # 229072

DR. DR

DR. PHONE# 907-000-0000

DRUG NAME: CELEBREX 200MG CAPSULE 200MG C SEARLE LAB AWP 02/02/2003

GENERIC NAME: CELECOXIB (ce-le-KOX-ib)

COMMON USES: This medicine is a nonsteroidal anti-inflammatory drug (NSAID) known as a COX-2 inhibitor used to relieve the symptoms of osteoarthritis and rheumatoid arthritis in adults. It is also used to treat acute pain or menstrual pain and discomfort. It may also be used to treat other conditions as determined by your doctor. This drug works by blocking the enzyme in your body that makes prostaglandins. Decreasing prostaglandins helps to reduce pain and swelling.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. This medicine may come with a patient information leaflet. Ask your doctor, nurse, or pharmacist any questions you may have about this medicine. Take this medicine with food. STORE THIS MEDICINE at room temperature between 59 and 86 degrees F (15 and 30 degrees C) in a tightly-closed container, away from heat and light. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do NOT take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to aspirin or any medicine containing aspirin or to a nonsteroidal anti-inflammatory drug (such as Feldene, Motrin, Naprosyn, Clinoril). DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to a sulfonamide antibiotic (Septra DS, Bactrim DS, Gantrisin). A severe reaction includes a severe rash, hives, breathing difficulties, or dizziness. If you have a question about whether you are allergic to this medicine, contact your doctor or pharmacist. IF YOU EXPERIENCE difficulty breathing; tightness of chest; swelling of eyelids, face, or lips; or if you develop a rash or hives, tell your doctor immediately. Do not take any more doses of this medicine unless your doctor tells you to do so. DO NOT EXCEED THE RECOMMENDED DOSE or take this medicine for longer than prescribed without checking with your doctor. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. THIS MEDICINE MAY CAUSE stomach bleeding. If you drink alcohol on a daily basis, do not take this medicine without first discussing it with your doctor. Alcohol use combined with this medicine may increase your risk for stomach bleeding. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes any medicines that contain aspirin, ibuprofen, naproxen, or ketoprofen. Aspirin as prescribed by your doctor for reasons such as heart attack or stroke prevention (i.e., non-arthritis doses) should be continued. CAUTION IS ADVISED when this medicine is used in the elderly, as they may be more sensitive to the side effects of this medicine. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while taking this medicine

ACCOMPANY EACH PRESCRIPTION

Pi

EAGLE RIVER, MN 55121
907-694-7007

***** PATIENT INFORMATION LEAFLET *****

DATE: February 12, 2003
PATIENT: DOE JOHN

RX # 229068
DR. DR

DR. PHONE# 907-000-0000

DRUG NAME: PREVACID 30MG DR CAP 30MG DR C TAP AWP 01/17/2002
GENERIC NAME: LANSOPRAZOLE (lan-SOE-pra-zole)

COMMON USES: This medicine is a proton pump inhibitor used to treat ulcers, gastroesophageal reflux (GERD), erosive esophagitis, or Zollinger-Ellison syndrome. It may also be used to treat other conditions as determined by your doctor.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. TAKE THIS MEDICINE in the morning unless your doctor directs otherwise. TAKE THIS MEDICINE before eating. SWALLOW WHOLE. Do not break, crush, or chew before swallowing. IF YOU HAVE TROUBLE SWALLOWING THE CAPSULE, check with your pharmacist to see if capsule may be opened. STORE THIS MEDICINE at room temperature between 59 and 86 degrees F (15 to 30 degrees C) away from light and moisture. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS DRUG IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment include headache, diarrhea, gas, or constipation. If they continue or are bothersome, check with your doctor. CONTACT YOUR DOCTOR IMMEDIATELY if you experience stomach/abdominal pain, rash, back pain, unusual tiredness, dizziness, vomiting, chest pain, dark urine, yellowing eyes or skin, persistent fever or sore throat, easy bruising or bleeding. IF YOU EXPERIENCE difficulty breathing; tightness of chest; swelling of eyelids, face, or lips; or if you develop a rash or hives, tell your doctor immediately. Do not take any more doses of this medicine unless your doctor tells you to do so. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

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FAMILY PHARMACY
11432 BUSINESS BLVD
EAGLE RIVER, AK 99577
907-694-7007

***** PATIENT INFORMATION LEAFLET *****

DATE: February 12, 2003

PATIENT: DOE JOHN

RX # 229067

DR. DR

DR. PHONE# 907-000-0000

DRUG NAME: FLUOXETINE 20MG CAP 20MG C PAR AWP 03/22/2002

GENERIC NAME: FLUOXETINE (floo-OX-uh-teen)

COMMON USES: This medicine is a selective serotonin reuptake inhibitor (SSRI) used to treat depression, obsessive-compulsive disorder (OCD), or bulimia. This medicine may also be used to treat PMS (premenstrual syndrome). It may also be used to treat other conditions as determined by your doctor.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. TAKE THIS MEDICINE WITH FOOD if it upsets your stomach. STORE THIS MEDICINE at room temperature, away from heat and light. CONTINUE TO TAKE THIS MEDICINE even if you feel better. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: UP TO 4 WEEKS MAY PASS before this medicine reaches its full effect. Do not stop taking this medicine without checking with your doctor. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. Using this medicine alone, with other medicines, or with alcohol may lessen your ability to drive or to perform other potentially dangerous tasks. THIS MEDICINE WILL ADD TO THE EFFECTS of alcohol and other depressants. Ask your pharmacist if you have questions about which medicines are depressants. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes any medicines that contain dextromethorphan. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. THIS MEDICINE IS EXCRETED IN BREAST MILK. The manufacturer of this medicine states that taking this medicine while breast-feeding is not recommended. CONSULT WITH YOUR DOCTOR ABOUT BREAST-FEEDING.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include nervousness, trouble sleeping, headache, drowsiness, fatigue, nausea, vomiting, diarrhea, loss of appetite, dry mouth, sweating, dizziness, lightheadedness, muscle spasms, or changes in sexual function. If they continue or are bothersome, check with your doctor. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

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907-694-7007

***** PATIENT INFORMATION LEAFLET *****

DATE: February 12, 2003
PATIENT: JOHN DOE

RX # 229071
DR: DR

DR. PHONE# 907-000-0000

DRUG NAME: ALBUTEROL INH MG I ANDRX PHAR AWP 09/23/2002
GENERIC NAME: ALBUTEROL (al-BYOO-ter-ole)

COMMON USES: This medicine is a bronchodilator used to treat or prevent the symptoms of asthma, emphysema, and other breathing conditions. This medicine is also used to prevent the symptoms of exercise-induced asthma. It may also be used to treat other conditions as determined by your doctor.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. THIS MEDICINE MAY COME with an instruction leaflet. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine. BEFORE USING THIS MEDICINE, be sure that the canister is properly inserted into the inhaler unit and SHAKE WELL. Exhale slowly and deeply. UNLESS YOUR DOCTOR HAS TOLD YOU OTHERWISE, position the mouthpiece between your lips and try to rest your tongue flat. Your doctor may have told you to hold the inhaler 1 or 2 inches (2 or 3 centimeters) away from your open mouth or may have instructed you to use a special spacing device. AS YOU START TO TAKE A SLOW, DEEP BREATH, PRESS THE CANISTER AND MOUTHPIECE TOGETHER at exactly the same time to administer a dose of this medicine. Continue inhaling slowly and deeply and hold your breath for as long as comfortable, then exhale slowly through pursed lips or through your nose. If more than 1 inhalation is to be used, wait a few minutes and repeat the above process. KEEP THE SPRAY AWAY from your eyes. KEEP TRACK OF THE NUMBER of sprays you use and subtract this number from the number of doses in the container. This will help you know when the container is becoming empty. STORE THIS MEDICINE at room temperature, away from extreme temperatures and direct sunlight. Do not puncture, break, or burn container, even if it appears empty. IF YOU MISS A DOSE OF THIS MEDICINE and you are using it regularly, use it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule.

CAUTIONS: KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are using this medicine. BEFORE YOU HAVE ANY MEDICAL OR DENTAL TREATMENTS, EMERGENCY CARE, OR SURGERY, tell the doctor or dentist that you are using this medicine. AVOID LARGE AMOUNTS OF caffeine-containing foods and beverages, such as coffee, tea, cocoa, cola drinks, and chocolate. Before switching brands of this medicine, consult your doctor or pharmacist. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. FOR WOMEN: IF YOU PLAN ON BECOMING PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. DO NOT BREAST-FEED while taking this medicine.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include fast heartbeat, nervousness, tremors, headache, difficulty sleeping, or nausea. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience rash, hives, itching, wheezing, or increased difficulty breathing. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

Brand
only

Both Brand &
Generic

Family PHARMACY  907-694-7007
11432 Business Blvd.
Eagle River, AK 99577

CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.
RX#229068 DR.DR 2/12/03
JOHN, DOE
TAKE ONE CAPSULE ONCE DAILY

PREVACID 30MG DR CAP 30
NO REFILLS PC RX EXP: 2/12/04

Family PHARMACY  907-694-7007
11432 Business Blvd.
Eagle River, AK 99577

CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.
RX#229072 DR.DR 2/12/03
DOE, JOHN
TAKE ONE CAPSULE ONCE DAILY

CELEBREX 200MG CAPSULE 60
NO REFILLS PC RX EXP: 2/12/04

Family PHARMACY  907-694-7007
11432 Business Blvd.
Eagle River, AK 99577

CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.
RX#229067 DR.DR 2/12/03
JOHN, DOE
TAKE ONE CAPSULE ONCE DAILY

FLUOXETINE 20MG CAP 100
W/F: PROZAC 20MG CAP
NO REFILLS PC RX EXP: 2/12/04

Family PHARMACY  907-694-7007
11432 Business Blvd.
Eagle River, AK 99577

CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.
RX#229071 DR.DR 2/12/03
DOE, JOHN
INHALE AS DIRECTED

ALBUTEROL INH 17
W/F: PROVENTIL 90MCG AER
NO REFILLS PC RX EXP: 2/12/04

**COMMITTEE: House Health,
Education and Social Services
Standing Committee**

**SUBJECT:
HB 51 LABELING OF PRESCRIBED DRUGS**



DATE: February 13, 2003

PLEASE SIGN IN

**PLEASE PRINT:
NAME & TITLE**

ADDRESS

PHONE

REPRESENTING
(No acronyms unless for a state agency,
please)

**DO YOU
WANT TO
TESTIFY?**

April L. Sopp Asst Nurse Mngr	8172 Thunder St	4633471	Public Health Policy Course (UAA)	No
E-mail address:	bradleysgirl77@hotmail.com			
Rebecca Tully RN	2870 LINDA AVE	789-5737	Public Health Policy Course (UAA)	No
E-mail address:	rtully2@excite.com			
Marie Carlson			AARP	Yes
E-mail address:				
Rosalie Walker		586-2877	OPAG	No
E-mail address:				
E-mail address:				