Standard of Practice

Prescribing Requirements

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Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in the *Regulated Health Professions Act*, Regulations, and Bylaws. All members must comply with Standards of Practice of Medicine, per section 86 of the *Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of the *Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

PREAMBLE

Medicine and Pharmacy are two professions that are often jointly involved in the management of the same patient. Unfortunately, the pharmacist and physician often have very little direct contact with each other on a matter. The two individuals may never have met each other and may not totally understand each other's responsibilities. This Standard of Practice attempts to improve this liaison and ensure better access to quality safe prescribing for Manitobans.

1. Application and Definitions

1.1. Prescribe[1] and Prescription[2] includes both prescriptions in the community and what are commonly called “orders” in hospital and residential healthcare institutions. Only the requirements in Part B apply to prescribing for hospital inpatients and residential health care institutions.

1.1.1 Hospitals include healthcare facilities owned and operated by the Government or a Health Authority (including Personal Care Homes and other Government-run residential care facilities).

1.1.2 Residential healthcare institutions are defined as privately-owned residential care settings.

[1] Prescribe is defined as, “to issue a prescription for a dental appliance, drug, vaccine, vision appliance, or wearable hearing instrument.” *RHPA,* s. 3

[2] Prescription is defined as, “in respect of a drug or vaccine, a direction to dispense a stated amount of a drug or vaccine specified in the direction of the individual named in the direction.” RHPA, s. 3

Part A – Prescribing in the Community

2. Before Prescribing

2.1 Prescribers **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

2.2 Before prescribing a drug, prescribers **must** meet the following requirements. These requirements are subject to the limited exceptions specified in Section 6.3:

- 2.2.1 complete an appropriate clinical assessment of the patient;
- 2.2.2 document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information;
- 2.2.3 consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and
- 2.2.4 obtain informed consent.

3. Content of Prescriptions

3.1. Prescribers **must** ensure the following information is included on every written or electronic prescription:

- 3.1.1. the prescriber's printed name, signature[3], practice address, and CPSM registration number;
- 3.1.2. the patient's name and either date of birth or Personal Health Identification Number (PHIN) (for M3P drugs, the patient's address, date of birth, and PHIN must be included);
- 3.1.3. the name of the drug;
- 3.1.4. the drug strength, quantity, and formulation (tablet, liquid, patch);
- 3.1.5. the dose and directions for use;
- 3.1.6. the full date the prescription was issued (day/month/year);
- 3.1.7. the total quantity and interval between part-fills must be specified for:
  - 3.1.7.a any medication on the M3P dug list
  - 3.1.7.b any medications that are classified federally as a narcotic or a controlled substance (refer to the Appendix for a complete listing of these medications);
- 3.1.8. for all other medications, refill instructions must be specified;
- 3.1.9. a method to contact the prescriber (telephone number[4], email address, or facsimile number).

[3] Paper prescriptions handed to the patient must be **signed in ink** by the prescriber. Electronically transmitted prescriptions may be signed electronically. Rubber stamped signatures are not permitted.

[4] This can be the hospital, clinic, or institutional phone number. If desired, a prescriber may also include a personal phone number on prescriptions intended for electronic transmission (i.e., faxed directly to pharmacy and not handed to the patient).

3.2. Prescribers **must** use their professional judgment to determine whether it would be beneficial to include any additional information on the prescription such as the patient's weight or date of birth and either the diagnosis, clinical indication, or treatment goal or a combination thereof be included on the prescription. In exercising their professional judgment, it is important for the prescriber to understand how this additional information may be beneficial to the pharmacist who is filling the prescription and the patient who is taking the medication. See the Contextual Information and Resources document following this Standard for guidance on this matter.

3.3. If the prescriber is an associate registrant (Resident, Physician Assistant, Clinical Assistant), the prescription must also include:
- 3.3.1. their designation (e.g., PA or ClA);
- 3.3.2. the treatment goal and/or diagnosis and/or clinical indication; and
- 3.3.3. the name of their supervising physician.

4. Format of Prescriptions including Verbal Prescribing

4.1. Prescriptions may be handwritten (legibly), electronically generated in accordance with the Practice Direction Electronic Transmission of Prescriptions, verbally relayed, or in the physician's order sheet in a hospital, Personal Care Home, or residential healthcare institution as per Part B of this Standard.

4.2. Verbal prescriptions for all drugs must include all information included in section 3.1 above other than the signature and prescription issue date.

4.3. Verbal prescriptions are permitted for all drugs and substances, subject to section 7 of this Standard and any institutional policies.

5. Sample Medication

5.1. A registrant must:
- 5.1.1. keep sample medication in a secure location;
- 5.1.2. dispose of sample medication in a safe and environmentally acceptable manner;
- 5.1.3. not offer to sell or barter sample medication for any purpose whatsoever; and
- 5.1.4. not have any form of material gain from distributing the sample medication.

5.2. A registrant must ensure if a sample drug is provided to the patient it is provided with clear instructions for its use, including any precautions, and it is not expired.

6. Direct Patient Contact

6.1 In most cases, prescribing medication or counter-signing a prescription without direct patient contact does not meet an acceptable standard of care. The requirements of section 2 and this section must be met for most prescriptions. These requirements are subject to limited exceptions specified in section 6.3. There is no direct patient contact when the registrant only relies upon a mailed, faxed or an electronic medical questionnaire.

6.2 The registrant **must** demonstrate there has been:

- 6.2.1 a documented patient evaluation by the registrant signing the prescription, that includes an adequate history and physical examination (subject to the requirements of the Standard of Practice – Virtual Medicine), to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;
- 6.2.2 sufficient direct dialogue between the registrant and patient regarding treatment options and the risks and benefits of treatment(s);
- 6.2.3 a plan for follow-up to review the course and efficacy of treatment to assess therapeutic outcome, as needed; and
- 6.2.4 maintenance of a contemporaneous medical record that can be accessed by the registrant, and be made available to the patient, and the patient's other healthcare professionals.

6.3 Exceptions exist to the direct patient contact requirement when the registrant:

- 6.3.1 is fulfilling responsibilities as part of a call group, true group practice or healthcare institution. In these scenarios registrants must reasonably satisfy themselves that:
  - 6.3.1.a. the healthcare professional who conducted the assessment has the appropriate knowledge, skill, and judgment to do so, and
  - 6.3.1.b. the prescription is clinically sound and, in the patient's, best interest;
- 6.3.2 treats their own patients after normal office hours;
- 6.3.3 works in an academic teaching environment;
- 6.3.4 is providing naloxone as part of a harm reduction strategy and overdose prevention;
- 6.3.5 prescribes prophylaxis as part of a Public Health Program;
- 6.3.6 prescribes for the sexual partner of a patient with a sexually transmitted infection;
- 6.3.7 prescribes anti-retroviral medication within the context of the Provincial HIV program; or
- 6.3.8 prescribes a medication available in Manitoba without requiring a prescription (e.g., an over-the-counter medication such as acetaminophen).

7. Manitoba Prescribing Practices Program (M3P Drugs)

7.1. Physicians **must** prescribe the drugs listed on the M3P schedule in the manner prescribed in the Regulation and this Standard.

7.2. Section 7 of this Standard does not apply to:

7.2.1. prescriptions for drugs administered in a personal care home as described under the Manitoba Health Services Insurance Act;

7.2.2. prescriptions for drugs administered in a hospital or institutional residential healthcare facility; and

7.2.3. the direct administration of a designated drug to a patient by a prescriber.

7.3. All prescription drugs on the M3P Schedule must be written on a prescription form as is approved by CPSM.

7.4. The treatment goal, and/or diagnosis, and/or clinical indication(s) **must** be included for all M3P prescriptions.

7.5. The prescription **must** contain only one drug per prescription form.

7.6. The prescription is only valid for three days after its issuance to the patient and the physician **must** so advise the patient.

7.7. Prescribers **must** prescribe in accordance with the Practice Direction for Prescribing Methadone or Buprenorphine/naloxone.

Part B - Prescribing in a Hospital, Personal Care Home, or Residential Healthcare Institution (Orders)

8. Prescribing

8.1 Prescribers in the facilities listed in sections 1.1.1. and 1.1.2 **must** ensure the following:

Content of prescription orders:

8.1.1. the name of the drug;

8.1.2. the drug strength and formulation (tablet, liquid, patch);

8.1.3. the dose and directions for use (for example the exact time of administration, if applicable);

8.1.4. the full date and time the prescription was issued (hour/day/month/year); and

8.1.5. the prescriber's printed name and signature.

9. Before Prescribing in a Hospital, Personal Care Home, or Residential Healthcare Institution

9.1. Prescribers **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

9.2. Before prescribing a drug, prescribers **must:**

9.2.1. document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information (as reasonably appropriate);

9.2.2. consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and

9.2.3. use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight or date of birth where this information would affect dosage).

9.3. For verbal prescribing/orders, in addition to the requirements under section 9.1 and 9.2, prescribers **must**:

9.3.1 provide the verbal order to a nurse or pharmacist, including all required content;

9.3.2 ensure if a voice message is left that a direct callback number is included to facilitate the nurse or pharmacist calling back and verifying the verbal order directly with the prescriber. A verbal order is not considered valid until a nurse or pharmacist speaks directly with the prescriber to verify the order; and

9.3.3 sign the order within a reasonable timeframe if required by the institution's operating policy.

APPENDIX

MEDICATIONS FEDERALLY CLASSIFIED AS NARCOTICS OR CONTROLLED SUBSTANCES

As per section 3.1.7, **total quantity** and **interval between part-fills** (i.e., number of days at which each quantity is to be dispensed) must be specified for:

- Any medications on the **M3P drug list and**
- Medications classified federally as a **narcotic** or **controlled substance**.

Medications that are classified federally as narcotics or controlled substances are listed in the schedules to the *Controlled Drugs and Substances Act (CDSA)*. The commonly prescribed CDSA medications that are not on the M3P drug list are:

1. Non-M3P Opioids/Narcotics

- All codeine containing preparations – that is products containing codeine plus two or more active non-narcotic ingredients (e.g. Tylenol #2®, Tylenol #3®, Cotridin liquid).
- All "Exempted codeine preparations" – that is products containing codeine up to 8 mg per tablet OR 20 mg codeine/30mL of liquid plus two or more active non-narcotic ingredients. (e.g., Tylenol #1® and generics, Calmylin® with codeine, Mersyndol® with 8 mg codeine, Robaxacet-8®).

2. Non-M3P Stimulants (Part I Controlled Drugs)

- Lisdexamfetamine (Vyvanse®) and generic equivalents
- Methylphenidate MLR (Biphentin®) and generic equivalents
- Methylphenidate OROS (Concerta®) and generic equivalents
- Methylphenidate CR (Foquest®) and generic equivalents

Note: Other stimulants (e.g., Ritalin®, methylphenidate IR, Adderall®, Dexedrine®) are on the M3P drugs list.

3. Non-M3P Controlled Drugs (Part II and III Controlled Drugs)

- Anabolic steroids (e.g., all formulations of testosterone)
- Phenobarbital

Note: Several barbiturates are on the M3P drug list, including phenobarbital with codeine, secobarbital, butalbital, and pentobarbital.

The full list of Part II and III controlled drugs can be found in the Schedule to Part G of the Food and Drug Regulations.