



[Insert pharmacy logo]

TEAM Program: Working Together for Healthy Blood Pressure

REQUEST FOR MEDICATION REVIEW [RMR] – Letter to Prescriber

Date: _____

Prescriber: _____ Fax: _____ Tel: _____

Patient: _____ DOB: _____ Tel: _____

Pharmacy: _____

Background

Our pharmacists are concerned about the risks of uncontrolled hypertension in African Americans. This is why we are evaluating a new hypertension monitoring program in a study funded by the National Heart, Lung, and Blood Institute. The program is called the TEAM Program because it involves specially trained pharmacy teams working with patients and their providers to improve medication adherence, lifestyle change, and blood pressure control. It is focused on African Americans because hypertension is more common and severe in this group.

Our goal is to help patients achieve a BP < 140/90 mmHg (or BP < 130/80 mmHg in patients with diabetes or chronic kidney disease), as recommended by JNC guidelines. To accomplish this goal, we would like your help.

1. The attached form reports your patient's blood pressure taken at our pharmacy, any side effects or adherence issues, and recommendations. Please review and let us know your recommendations. You may call or fax the form back to us.
2. If you wish to adjust the patient's regimen, you may fax a prescription along with this form. We will contact the patient, modify the prescription(s) as requested, and follow-up with you as necessary.

Thanks for your response! We look forward to working with you and your patient.

Pharmacist(s): _____

Telephone: _____ Fax: _____



Request for Medication Review (RMR)

Patient: _____ DOB: _____ Allergies: _____ Date: _____

Provider: _____ Provider Fax: _____

A. Current medications for hypertension:	B. Blood pressure taken at our pharmacy			
1.	Date	Blood pressure	Date	Blood Pressure
2.				
3.				
4.				
C. Goal blood pressure according to JNC Guidelines: <input type="checkbox"/> < 140/90 mm Hg or <input type="checkbox"/> < 130/80 mm Hg				

D. Pharmacist Assessment. PATIENT has...

<input type="checkbox"/> uncontrolled blood pressure	<input type="checkbox"/> low awareness of BP goal
<input type="checkbox"/> adherence problem (missed doses or late refills)	<input type="checkbox"/> low physical activity (< 30 min on most days)
<input type="checkbox"/> poor understanding of drug regimen or purpose	<input type="checkbox"/> high sodium intake
<input type="checkbox"/> unwanted side effects	<input type="checkbox"/> weight problem (BMI ≥ 25)
<input type="checkbox"/> difficulty paying for medication	<input type="checkbox"/> interest in adjusting or changing drug therapy
<input type="checkbox"/> difficulty remembering medication	<input type="checkbox"/> other
Notes:	

E. Pharmacist Plan and Recommendations to Prescriber

<p><u>Plan:</u> <input type="checkbox"/> Educated patient about BP goal and importance of monitoring <input type="checkbox"/> Offered adherence aid and counseling</p> <p><input type="checkbox"/> Discussed options for managing side effects <input type="checkbox"/> Discussed cost-lowering options <input type="checkbox"/> Educated about lifestyle</p> <p><input type="checkbox"/> Patient will return to pharmacy for BP and adherence monitoring <input type="checkbox"/> Patient referred to doctor for evaluation</p> <p><u>Recommendations:</u> <input type="checkbox"/> Continue current therapy <input type="checkbox"/> If appropriate, please consider:</p>
Pharmacist Signature: _____ Date: _____

F. Physician Recommendations (attach new prescription or authorization if needed)

<p><input type="checkbox"/> Denied <input type="checkbox"/> Authorize new prescription or change (see attached prescription or authorization)</p> <p>Note:</p> <p>Signature: _____ Date: _____</p>
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Thanks for your response! Please return this note to the pharmacist at FAX #: _____

Or call the pharmacist at TEL#: _____

Procedures for Contacting Prescribers

A. Overview

The attached consultation form, “Request for Medication Review” (RMR), was designed to facilitate pharmacist contact with PCPs by FAX or mail, if appropriate. The cover page provides background information about the TEAM program. The second page provides space for easy noting of BP readings, problems, recommendations, and PCP response.

Following are several recommendations for contacting PCPs. As usual, the pharmacist still must use his or her professional judgment to determine:

- when the initial contact with a PCP should be made;
- what contact method should be used (fax, mail, or phone);
- how often contact should be attempted; and
- how to overcome barriers to collaboration (e.g. PCP inertia, nonresponse, time).

B. The following procedures are recommended:

1. PCPs will be contacted if the pharmacist identifies intolerable side effects or suboptimal drug therapy for HTN, as recommended in the JNC algorithm for treatment of HTN.
2. PCPs will be contacted if the patient’s BP is severely elevated (systolic BP >210 mmHg or diastolic BP >115 mmHg). [The IRB-approved protocol requires that patient will be given oral and written instruction to seek immediate medical evaluation if BP is severely elevated.]
3. PCPs will be faxed or mailed a RMR if the patient still has not achieved goal BP by Month 3. The 3-month RMR will include a list of BP readings at the pharmacy, unresolved issues, pharmacist recommendations, a link to JNC7, and space for PCP response via fax.
4. The pharmacy technician may assist the pharmacist in contacting PCPs, maintaining records, and follow-up if needed.