

## Continued Dispensing of PBS Medicines in Defined Circumstances

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Organisation	Services for Australian Rural and Remote Allied Health (SARRAH)
Address	P.O. Box 74 Deakin West ACT 2600
Contact Information	Rod Wellington – Chief Executive Officer BH – 02) 6285-4960 Email – <a href="mailto:rod@sarrah.org.au">rod@sarrah.org.au</a>  This paper was produced with the assistance of Lindy Swain Pharmacist Academic and member of the SARRAH Advisory Committee.

Currently the Commonwealth and state and territory legislation requires that a pharmacist must receive the original copy of a prescription before a Prescription-Only Medicine (Schedule 4) or a Controlled Drug (Schedule 8) is dispensed. Legislative changes will be implemented to enable the supply and PBS claiming of SOME medicines under the Continued Dispensing Initiative.

The aim of the Continued Dispensing initiative is to prevent treatment interruption of chronic therapy medicines due to an inability to obtain a timely prescription renewal. It is important the pharmacist is confident that ongoing therapy is intended.

**SARRAH strongly supports the continued dispensing (CD) initiative. SARRAH would support a much expanded list of PBS medications which could be supplied by pharmacists to patients under defined circumstances.**

CD is a much needed initiative in rural and remote areas across Australia where:

- The scarcity of medical practitioners means it is difficult for patients to arrange appointments.
- The high turnover and lack of continuity of general practitioners means it is difficult, if not impossible, to obtain owing prescriptions.
- Accessing a medical practitioner may be difficult due to distance, lack of transport and/or financial burden.

CD is a much needed initiative for Aboriginal and Torres Strait Islander patients who obtain free chronic disease medication under the Close the Gap (CTG) program. This assumes that this initiative allows pharmacists to seek payment for these patients even without a prescription. This is not specifically mentioned in the Consultation Paper guidelines and needs to be clarified. How will the pharmacist determine if the patient is eligible for CTG? The onus for this currently rests with the General Practitioner. Emergency supply which requires payment as a private prescription is often not an option for Aboriginal and Torres Strait Islander people. Aboriginal people often move frequently due to family, social and community obligations and thus the sourcing of prescriptions can be difficult. These factors often result in poor medication concordance.

CD is a much needed initiative to address ongoing compliance of medications but it needs to be applied to a much wider group of medications than oral contraceptives and HMG CoA reductase inhibitors (statins) before it is useful to chronic disease patients. The limited categories included in

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this initiative imply that pharmacists are unable to effectively interview patient and assess side effects. SARRAH believes that pharmacists are more than capable to do this if adequate education is provided and protocols are established.

Due to PBS criteria to qualify for subsidised lipid therapy there are not many patients on “statins” alone. The majority of patients on statins will also be taking diabetic or antihypertensive medications. When these patients go to the Doctor they will get prescriptions for all their medicines and so not use the “CD” program which needs to be considered when assessing the success of the program. The other consequence could be that the patient does use the CD option for their statin and therefore takes only the “statin”, not anti-hypertensive and/or diabetes medication.

It will be very difficult for the pharmacist to explain to the patient why they can give CD of some medications and not others. Pharmacists will be under pressure to provide “CD” for many medications. Some pharmacists may choose not to participate in this initiative as it causes too much confusion for their patients. Another consequence is that pharmacists may not receive owing scripts for other medications, or have to work harder to get their owing scripts as the Doctor and/or patient may misunderstand why they need a script for some medicines and not others.

Does the 20 day rule need to apply to CD? CD will be useful for continuity of supply for patients who are away from home and have forgotten to take their medications with them. They may not qualify for continued dispensing if the 20 day rule is applied. CD in many cases will be a 1 off supply before a patient returns to their prescriber so is not open to the abuse/hoarding that the 20 day rule was implemented to fix.

### Discussion of Questions in Consultation Paper

#### 1. a) Legitimising Request

Option: Method of Verification	Appropriate? (Yes/No) Additional comments may be included
Dispensary computer record (previously dispensed in pharmacy)	Yes
Empty labelled medicine container provided to pharmacist (no dispensary computer record)	Yes
Phone verification from prescriber or other medical practitioner	Yes
Phone/electronic verification from pharmacist located in patient’s regular pharmacy that requested item has been previously supplied based on a valid prescription	Yes
Medication profile provided by patient/carer	Yes – if recent and written by a doctor, pharmacist, or other health practitioner
Expired prescription provided to pharmacist	Yes
Electronic notification by Medicare Australia to pharmacy that a claim for the requested item has been processed	Yes – if current

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b) Others steps to verify legitimacy may include:

- Hospital/hospice/residential care/prison discharge records.
- Aboriginal Health service record verification.
- E-health records.

### 2. PBS/RPBS Claiming

- Pharmacists would need to keep complete records of all “CD”.
- Patients should have to sign a “CD” book or form.
- Pharmacists would have to submit a set of “CD” books or forms for auditing purposes.

### 3. a. Developing Protocols and Guidelines

- Pharmacists should be able to make judgements based on clinical reasoning not just on policing of paperwork and rules. The main protocol should be risk vs. benefit - Is the patient at risk if the medication is not taken? Is the patient at any risk if the medication is supplied?
- Pharmacists need to follow protocols to determine if the patient is suffering any medication side effects and to ensure medication usage is safe, that is correct dosing and checking for drug interactions.
- The intervention should be used to discuss lifestyle issues such as smoking, diet and exercise.

### 3. b. Emergency Supply Arrangements

- Yes, supply arrangements should be covered by protocols, standards and guidelines.

### 4. Absence of a Valid Prescription

The benefits of CD are that the prescriber does not have to be contacted and the PBS subsidy still applies. This allows for medication supply in areas where there is either no General Practitioner, no readily accessible General Practitioner, a high turnover of General Practitioners or lack of continuity such as in rural and remote Australia and in some Aboriginal Health services.

The scenarios do not allow for where there is no or very limited availability of doctors. This is not just in remote areas but in many rural country towns which have difficulty retaining doctors.

The parameters outlined in the consultation paper specify that medication supply occurs until the patient sees their prescriber. If there is no available prescriber, this could be a long period. The pharmacist needs to be given authority, such as that obtained by some nurse practitioners, to clinically prescribe in rural and remote areas. The pharmacist needs to be able to access patient medical records via E-health, including pathology results and titrate doses.

In some locations hospitals dispense PBS prescriptions. CD should apply to hospitals and Aboriginal medical services undertaking PBS dispensing.

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Pharmacists should complete a Continuing Professional Development (CPD) module and examination on each therapeutic group available for CD to ensure appropriate knowledge levels are maintained. Pharmacists need to have completed this assessment before being able to claim on PBS for medications supplied by CD. The CPD module should outline questions which need to be asked and counselling tips given when supplying medication by CD.

Protocols for CD must include carers/family members being allowed to collect medication for patients where the patient is unable to attend a pharmacy and/or when the pharmacist feels that their claim for CD falls within defined parameters.

### 5. AIM of CD

- Will the maximum period of “legitimised” supply be specified? The parameters for the pharmacist supplying medication need to be clearly defined. If a patient in need is for example unable to see a prescriber, and if there is no apparent reason to cease medication, the pharmacist should be able to supply medication for 6 months.
- Ideally the communication between pharmacist and prescriber should be electronic, by email until automated. Patients should and cannot be relied on to transfer pieces of documents.

### 6. Compliance Activities

- Pharmacists will need to keep a book, spreadsheet and/or forms with details of CD. This needs to be signed by the patient or carer collecting the medication. Pharmacists should be randomly and regularly audited.

### 7. Selection of medicines

- Chronic disease medicines with limited side effect and interaction profiles should be considered for CD.
- As each therapeutic group is considered suitable for CD, pharmacists must complete a training module.
- Cardiovascular, diabetes and asthma medications should be a priority.