Practice Direction

Electronic Transmission of Prescriptions

Initial Approval: November 22, 2018 **Effective Date: January 1, 2019**

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Practice Directions set out requirements related to specific aspects of the practice of medicine. Practice Directions are used to enhance, explain, or guide registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants must comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act.*

This Practice Direction is made under the authority of s. 85 of the RHPA and represents requirements of CPSM registrants in so far as appropriate.

This joint Practice Direction is the result of Interprofessional Collaboration between:

- College of Pharmacists of Manitoba (CPhM),
- College of Physicians and Surgeons of Manitoba (CPSM),
- College of Registered Nurses of Manitoba (CRNM),
- The Manitoba Dental Association (MDA), and
- The Manitoba Veterinary Medical Association (MVMA),
- The College of Podiatrists of Manitoba (COPOM)

Purpose

To better serve all patient populations (urban, rural, and remote) and to leverage the benefits of modern technology, the electronic transmission of prescriptions is necessary to ensure timely access to care. The purpose of this Practice Direction is to outline the minimum practice expectations for health professionals whose scope of practice includes prescribing. The Practice Direction clarifies the expectations of safeguards for electronic transmission of prescriptions.

1. Definition and Application

"Electronic transmission" is the communication of an original prescription or refill authorization by electronic means. This includes computer-to-facsimile machine[1], facsimile machine to facsimile machine, facsimile machine to computer, or via a closed e-prescribing system[2]. It does not include verbally transmitted prescriptions or prescriptions transmitted by email at this time.

This joint Practice Direction applies to all medications prescribed for outpatients and persons receiving care in an ambulatory community practice.

[1] For instance, a prescription sent by Accuro is converted into a fax and sent to the pharmacy's fax machine.
[2] For example, the PrescribeIT prescribing system

The Manitoba Prescribing Practices Program (M3P) will supersede this process when the drug being prescribed is covered under the M3P Program. Prescribers should refer to their respective regulatory body for further guidance.[3]

2. Electronic Transmission of Prescriptions

2.1. Principles

2.1.1. In consideration of patient safety and to minimize the risks associated with drug diversion, prescribers and pharmacists **must** adhere to the following principles:

2.1.1.a. The process **must** maintain confidentiality.[4] It **must** do so by either facsimile or closed e-prescribing system. Prescribers and pharmacists are jointly responsible for maintaining the confidential nature of electronic transmission.

2.1.1.b. The accuracy and authenticity of the prescription **must** be able to be validated.

2.1.1.c. The process **must** incorporate mechanisms to decrease prescription forgery risk and minimize the risk of the prescription being transmitted to more than one pharmacy unintentionally.

2.1.1.d. The patient's choice of pharmacy **must** be protected, taking into consideration the treatment plan and drug availability.

2.2 Shared Responsibility

2.2.1. To facilitate congruence with the above principles, prescribers and pharmacists have the following responsibilities:

2.2.1.a. The prescriber **must** ensure the prescription is transmitted directly to the pharmacist in a clear, unambiguous manner and the mode of transmission is secure and maintains confidentiality.

2.2.1.b. The pharmacist **must** only accept a prescription once satisfied that it came directly from someone who has the authority to prescribe and the prescription is appropriate for the patient. A pharmacist is also responsible for verifying a prescriber's written and/or electronic signature if it is unknown to the pharmacist.

2.2.1.c. Both prescribers and pharmacists **must** ensure that prescribing is done in accordance with each profession's scope of practice (as outlined by their regulatory body).

[3] CPSM Standard of Practice Prescribing Requirements, CRNM Practice Expectations for RN (NPs), CPhM Prescribing Practice Direction, MVMA PIPS By-laws, MDA Code Of Ethics.

[4] Veterinary prescriptions are exempt from the confidentiality requirement.

2.3. Safeguards

2.3.1. The following additional safeguards apply to electronic prescriptions:

2.3.1.a. All prescriptions transmitted electronically (except veterinary prescriptions) **must** be entered into the Drug Program Information Network (DPIN) to enhance patient care and safety, and to restrict opportunities for potential prescription fraud.[5]

2.3.1.b. After transmission, the prescriber **must** ensure the original prescription is invalidated to ensure it is not transmitted elsewhere at another time. A prescription record **must** be retained in accordance with the prescriber's regulatory body.

2.3.1.c. Pharmacists **must** ensure the electronic and facsimile equipment at the pharmacy is under the control of the pharmacist so the transmission is received and only handled by staff in the dispensary in a manner which protects the patient's privacy and confidentiality.[6] Prescriptions, including any relevant prescription information received by electronic transmission **must** be appropriately filed by the pharmacist in accordance with CPhM's record keeping requirements.

3. Content of Electronic Prescriptions

3.1. The prescription **must** be legible and **must** include the following information:

3.1.1. The prescriber's printed name, signature, practice address, and Registration number;

3.1.2. The patient's name and either date of birth or Personal Health Information Number (PHIN) (for M3P drugs, the patient's address, date of birth, and PHIN must be included).[7]

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 medication classified federally as 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. The time and date of prescription transmission.

[5] Should a patient request a drug that falls under the Controlled Drugs and Substance Act (CDSA) *not* be entered into DPIN under their PHIN (or if they do not have a Manitoba PHIN), a pharmacist must directly confirm prescription authenticity with the prescriber. Such drugs would include opioids, controlled medications, benzodiazepines, and targeted substances.

[6] For greater clarity, dedicated pharmacy electronic and/or facsimile equipment must not be accessed by individuals who are not authorized pharmacy staff.

[7] Veterinary prescriptions are exempt from PHIN and date of birth.

3.1.10. The name and address of the one pharmacy intended to receive the prescription.
3.1.11. The method to contact the prescriber (telephone number, email address, or facsimile number).
3.1.12. Signed certification that:
3.1.12.a. the prescription represents the original of the prescription drug order;
3.1.12.b. the addressee is the only intended recipient and there are no others; and
3.1.12.c. the original prescription will be invalidated, securely filed, and not transmitted elsewhere at another time.

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 the Standard of Practice for Prescribing Requirements for guidance on this matter.

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

3.4. If the prescriber is a CRNM Registrant (e.g., RN(NP)), a prescription **must** include a treatment goal and/or diagnosis and/or clinical indication.

3.5. If the prescriber is a CPhM Registrant (pharmacist), a prescription **must** include a treatment goal and/or diagnosis and/or clinical indication.

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.