



**State of New Hampshire  
Board of Pharmacy**  
7 Eagle Square  
Concord, NH 03301  
Tel: (603) 271-2350 Fax: (603) 271-2856  
Website: www.oplc.nh.gov/pharmacy/

**COLLABORATIVE PHARMACY PRACTICE APPLICATION**

PLEASE PRINT CLEARLY - ILLEGIBLE, INCOMPLETE OR APPLICATIONS WITHOUT THE REQUIRED ATTACHMENTS AS NOTED ON PAGE 2 CANNOT BE ACCEPTED.

1. GENERAL INFORMATION			
Applicant's Name	First	Middle	Last
	Morgan	Alison	SIMPSON
Mailing Address			
60 Alta Blvd #308 Lebanon, NH 03766			
NH Pharmacist License Number	Home or Cell Phone #	Work Phone #	Email Address (Must be entered to receive your updated license with CPP endorsement):
PHCY-01154	603-265-3603	603-653-3744	Morgan.A.Simpson@nitencock.org

2. CURRENT PHARMACY EMPLOYMENT ASSOCIATED WITH THIS COLLABORATIVE AGREEMENT	
Name of NH Pharmacy	
Dartmouth - Health	
Complete Mailing & Physical Address of NH Pharmacy	
One Medical Center Drive Lebanon, NH 03756 Attn: Level 2 inpatient pharmacy	

3. PROFESSIONAL LIABILITY INSURANCE AND CARDIOPULMONARY RESUSCITATION (CPR) CERTIFICATION	
I have at least \$1,000,000 of professional liability insurance with the following insurance provider <u>Hamden Assurance Risk Retention Group, Inc</u>	
* You <u>must attach</u> a copy of your certificate of insurance to this application.	
If also administering vaccines, I have <u>current</u> CPR certification, which includes the required 'hands-on' training which <u>must</u> be completed every 2 years, from (please check one):	
<input type="checkbox"/> American Heart Association	<input type="checkbox"/> American Red Cross
<input checked="" type="checkbox"/> Not Applicable - I Do Not Administer Vaccines	
* <u>If administering vaccines, you must attach</u> a copy of your certificate of completion of CPR training or a copy of the back & front of your signed CPR Card, which show it was completed in the past 2 years (i.e. has not passed the 'recommended date for refresher training').	

4. PRACTICE DISCIPLINE FOR THIS COLLABORATIVE PRACTICE AGREEMENT (ONLY ONE PRACTICE DISCIPLINE ALLOWED PER APPLICATION)	
Check <u>only one</u> :	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Anticoagulation
<input type="checkbox"/> COPD	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hypertlipidemia	<input type="checkbox"/> Hypertension
<input checked="" type="checkbox"/> Other (Describe): <u>Hematopoietic cell transplant - Discharge medications</u>	

5. SUMMARY OF EDUCATION, TRAINING, AND EXPERIENCE RELATED TO RESPONSIBILITIES TO PERFORM VIA THE COLLABORATIVE PRACTICE AGREEMENT:

- Completed Doctor of Pharmacy degree at SWSU in  
Weatherford, OK in 2020  
- Current Hematology/Oncology Clinical Pharmacist  
(06/2022-present) at Dartmouth-Health Lebanon, NH

6. APPLICANT ATTESTATION STATEMENT:

My signature below affirms that the answers and statements made on this application are true and correct to the best of my knowledge and belief. I also understand that pursuant to RSA 318:26-a, the Board must be notified within 15 days of any changes related to your collaborative practice agreement or in the information contained on this form. Failure to notify the Board could result in disciplinary action and/or sanctions.

Signature: Megan Simpson Date: 06.20.2022

7. EMPLOYER ATTESTATION STATEMENT:

As owner / chief administrative officer of Mary Hitchcock Memorial Hospital I certify that my Company agrees to be in compliance with all federal, state, and local laws related to this agreement. I have read this application and all of the statements made on it, reviewed all submitted supporting documents, attest that to the best of my knowledge, all provided information is true and accurate. As the owner/corporate representative of this organization, my signature below acknowledges my/the corporation's responsibilities as the permit holder, including all of the corporate/permit holder duties and responsibilities noted in NH RSA 318:30 and Ph 704.11(d).

Signature Of Organization Representative: [Signature] Title: CPO Date: 9/7/2022

\* LIST OF SUPPORTING DOCUMENTS WHICH MUST BE INCLUDED WITH THE APPLICATION:

Attach each of the following and label the top right of each attachment with the corresponding letter below (i.e. "Attachment A", "Attachment B", etc.)

- A. Copy of Signed Collaborative Agreement;
- B. Copy of Professional Liability Insurance Coverage/Certificate;
- C. Copy of Policy and Procedures governing the Collaborative Practice Agreement;
- D. Copy of Policy and Procedures for QA/CSI program
- E. Copy of Patient Consent Form;
- F. List of all Providers Whom Are Party to the Agreement - Full Name, Address and NH License;
- G. If administering vaccines, a copy of your certificate of completion of CPR training or a copy of the back & front of your signed CPR Card, which shows it was completed in the past 2 years (i.e. has not passed the 'recommended date for refresher training').

**CERTIFICATE OF INSURANCE** **DATE: August 25, 2022**

**COMPANY AFFORDING COVERAGE**  
 Hamden Assurance Risk Retention Group, Inc.  
 P.O. Box 1687  
 30 Main Street, Suite 330  
 Burlington, VT 05401

This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded by the policies below.

**INSURED**  
 Mary Hitchcock Memorial Hospital  
 Dartmouth-Hitchcock Pharmacy  
 1000 Quality Drive  
 Hooksett, NH 03106  
 (603)653-6850

**COVERAGES**

The Policy listed below has been issued to the Named Insured above for the Policy Period notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued. The insurance afforded by the policy is subject to all the terms, exclusions and conditions of the policy. Limits shown may have been reduced by paid claims.


TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
				EACH OCCURRENCE	
				DAMAGE TO RENTED PREMISES	
				MEDICAL EXPENSES	
				PERSONAL & ADV INJURY	
				GENERAL AGGREGATE	
<b>OTHER</b>				PRODUCTS-COMP/OP AGG	
<b>PROFESSIONAL LIABILITY</b>	0002022-A	07/01/2022	07/01/2023	EACH CLAIM	\$1,000,000
X CLAIMS MADE				ANNUAL AGGREGATE	\$3,000,000
OCCURENCE					
<b>OTHER</b>					

**DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)**  
**Morgan Simpson, RPh** is insured under the terms and conditions of Policy No: 0002022-A. Coverage is provided solely for acts/duties performed within the scope of employment for Dartmouth-Hitchcock Clinic. Any activities outside the scope and terms of employment with Dartmouth-Hitchcock Medical Center are expressly excluded and not covered by Policy No: 0002022-A. This insurance applies to services provided in the states of NH, VT, MA, MD and ME only.

**CERTIFICATE HOLDER**

NH Board of Pharmacy  
 Philbrook Building  
 121 South Fruit Street  
 Concord, NH 03301-2412

**CANCELLATION**  
 Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 DAYS written notice to the certificate holder named below, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.

**AUTHORIZED REPRESENTATIVES**  


# Collaborative Pharmacy Practice Agreement

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Hematopoietic Cell Transplant Discharge Medications  
Hematology/Oncology Pharmacy

Philip Benoit, PharmD, BCOP  
Samuel Breiner, PharmD  
Sean Casavant, RPh, BCOP  
Kori Costa, RPh, BCOP  
Melissa Drye, PharmD  
Kristen Grafenstein, PharmD  
Laura Hackett, PharmD, BCOP  
Caitlin Harper, PharmD  
Katie Karkowski, PharmD, BCOP  
Nicholas Nadeau, PharmD  
Ricki Nero, PharmD  
Alexandra Simms, PharmD  
Morgan Simpson, PharmD  
Gregory Wolfe, PharmD

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## Introduction

1. This Collaborative Pharmacy Practice Agreement (called the “CPA”) follows the New Hampshire Board of Pharmacy Administrative Rules Chapter Ph 1100 titled *Collaborative Pharmacy Practice* and NH RSA 318:16-a titled *Standards for Collaborative Pharmacy Practice*. A copy of the current version of the law and rules will be given to each pharmacist and attending practitioner (the “practitioner”) signing this CPA.
2. By entering into this CPA, each Norris Cotton Cancer Center (NCCC) pharmacist signing below (the “pharmacist”) is authorized to provide drug therapy management services as described in this CPA to the patient signing below (the “patient”) for the management of supportive care for patients who have undergone hematopoietic cell transplant (HCT). For the purposes of this agreement, supportive care will include prevention of infection, graft-versus-host disease (GVHD), seizures, and veno-occlusive disease (VOD).

## Purpose

In order to enhance collaborative patient care, the pharmacist will complement the care provided by the practitioner in this CPA and assist the practitioner to improve the quality of care provided to the patient for the management of supportive care. Upon receipt of a pre-hematopoietic cell transplant admission referral visit, referral order, a patient specific medication order, or as requested by NCCC clinical leadership, the pharmacist will order appropriate and necessary labs, authorize appropriate medication refills, and initiate, modify, or discontinue medications when appropriate for the patient at time of hospital discharge.

## Goals

1. To improve the HCT discharge medication process and ensure patient-centered care for optimal drug therapy results and improved patient outcomes;
2. To increase patient and practitioner access;
3. To improve cost-effective care to the patient;
4. To improve patient/caregiver self-management skills and adherence to drug therapy related to the prevention of GVHD and transplant-related infections.

## Term

This CPA is effective until the patient’s first post discharge provider visit, but no longer than two (2) years from the date of the patient’s signature below. The pharmacist, practitioner, or patient may terminate this CPA at any time, in writing, before the two (2) years are up. When the CPA is terminated for any reason, the pharmacist shall inform the patient and provide details to the patient to allow for the uninterrupted continuation of the patient’s medication therapy management.

## Services

1. Under this CPA, the pharmacist is authorized to refill, initiate, modify, and discontinue the specific drugs listed in [Appendix A, Table 3](#).
2. The specific terms and conditions under which the specific drugs listed in [Appendix A, Table 3](#) may be refilled, initiated, modified or discontinued are as follows:
  - a. When appropriate for the patient through the use of evidence-based medicine and the pharmacist’s clinical judgement.

3. If any of the following conditions or events occur, the pharmacist must notify the practitioner in writing within [24] hours:
  - a. In any urgent or life-threatening situations.
4. The frequency of visits and follow-up for the patient with the pharmacist is dependent on the clinical needs and management of the patient's clinical condition and may vary from days to months.
5. The pharmacist will provide services to the patient under the CPA only in a private exam room, office, or secluded area away from the hearing of other persons in compliance with the requirements of the Health Information Portability and Accountability Act of 1996 and the associated regulations ("HIPAA").
6. The pharmacist will have dedicated time scheduled for each type of CPA service for the patient. The expected amount of time the pharmacist will devote to these CPA services will depend on the needs of the hospital, size of the patient population, the patient and the availability of a HIPAA compliant space in which to provide services to the patient at the applicable division site.

## Scope

### General

This CPA authorizes the named pharmacists to monitor, assess, and prescribe the patient's discharge medications as they relate to supportive care:

1. Interviewing the patient and gathering health information related to the management of the patient's HCT may include, but is not limited to the following:
  - a. Medical and drug history
  - b. Social and family history
  - c. Lifestyle history
  - d. Vaccination history
  - e. Drug allergies and intolerances
  - f. Prescription insurance
  - g. Preferred outpatient pharmacy
2. Initiating, refilling, modifying, or discontinuing the medications detailed in [Appendix A, Table 3](#).
3. Ordering and assessing the drug therapies through the laboratory tests listed in [Appendix A, Table 4](#).

### Drug Therapy Management

Decisions regarding modifications of the patient's drug therapy and selection of drug therapy will be consistent with the recommendations in nationally recognized disease guidelines and primary literature detailed in [Appendix A, Table 2](#) and locally established guidelines.

1. The pharmacist may modify the drug therapy according to the nationally recognized disease guidelines in [Appendix A, Table 2](#), and use the pharmacist's clinical judgement in providing the services under this CPA. The specific drugs to be managed by the pharmacist are detailed in [Appendix A, Table 3](#).
2. The pharmacist may initiate, modify, discontinue, or refill the drugs listed in [Appendix A, Table 3](#).
3. The pharmacist may order laboratory tests listed in [Appendix A, Table 4](#) to assist in the management of medications listed on [Appendix A, table 3](#).

### Documentation and Record Keeping

1. Documentation for each CPA visit with the patient will be in a SOAP (subjective, objective, assessment, and plan) formatted notes in the patient's EMR. The pharmacist will have access to the patient's electronic medical record (EMR) and may access portions of the patient's record relevant to the management of supportive care.

2. A summary of each visit containing all drug therapy initiations, modifications, discontinuations, and refills, and individualized patient care plans will be documented by the pharmacist in the patient's EMR and routed to the practitioner no later than three (3) days after the patient's visit and sooner if urgent.
3. A copy of this CPA and associated protocols will be kept on file at the pharmacist's place of practice and be available on request.
4. The CPA will be reviewed at minimum yearly, and may be renewed, at a minimum of every 2 years (renewal requires signatures by the pharmacist, the practitioner, and the patient).
5. It is the responsibility of the pharmacist to ensure the executed CPA is scanned into the patient's EMR and filed as required by Risk Management.
6. If the CPA is terminated by either the pharmacist or practitioner, the patient must receive prompt written notification with details as to allow for uninterrupted continuation of their therapy management program.

## Communication

General: Documentation by the pharmacist through the patient's profile in the patient's EMR will be the primary method of communication by the pharmacist to the practitioner. Notification by the pharmacist to the practitioner may also be completed by the pharmacist via in-basket message, phone, fax, pager, email, or mail, as appropriate to the issue, the urgency and protecting the privacy and confidentiality of the patient's information as required under applicable law. Practitioner notifications of the patient's care plan and notice to the pharmacist of the same may occur by all the same routes of communication noted above. The pharmacist will implement the changes as specified by the practitioner or promptly will contact the practitioner for additional information/recommendations.

1. Discontinuation or Modification of Drug Therapy: the pharmacist must give the practitioner notification within 24 hours after closure of the note, except in urgent or life-threatening situations.
2. Urgent or Life Threatening Concerns: the pharmacist will notify the practitioner of any urgent or life-threatening concerns with respect to the patient immediately and pharmacist or practitioner will contact emergency medical services as medically appropriate.

## Quality Assurance



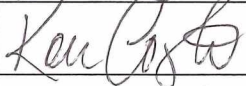
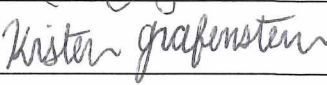
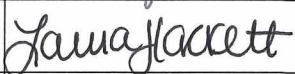
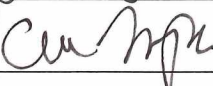





1. An annual review of the CPA will be performed by the pharmacist to determine whether changes need to be made, at the minimum once yearly. If a change is warranted, the pharmacist will notify the patient and the attending practitioner. A material amendment to the CPA must be signed by the pharmacist and the practitioner, to reflect any changes to or under this CPA and no changes will be effective until the amendment or a new CPA is signed by both parties. The pharmacist will provide written or electronic notification in accordance with applicable law and rules to the NH Board of Pharmacy ("NH BOP") within 15 days of changes made to the CPA, documentation, and or the original CPA application.
2. The quality metrics of this CPA will be reported to the NH BOP annually.
3. The CPA will be renewed if agreed upon by all parties that have signed the CPA, at the minimum every 2 years.
4. Peer or self-review of documentation notes in the patient's EMR will be performed by the pharmacist at least annually.
5. The management of supportive care for HCT patients will be continually monitored for improvement as part of the quality performance metrics detailed in Appendix A, Table 1.
6. Neither the practitioner nor the pharmacist shall seek to gain personal financial benefit by participating in any incentive-based program or accept any inducement that influences or encourages therapeutic or product changes.



## Collaborative Pharmacy Practice Agreement Pharmacist Practitioner Signatures


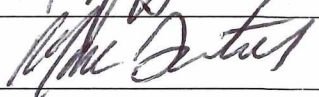


By signing this CPA, the pharmacist(s) named below agree to all of the terms and conditions of this CPA with the named practitioner(s) and patient who are also signing below.

1. Pharmacist name, address, NH license, signature, and date:




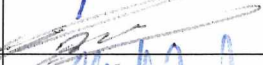


Pharmacist Name	Address	NH License	Signature	Date
Philip Benoit	1 Medical Center Dr. Lebanon, NH 03766	PHCY-00898		1/21/22
Sean Casavant	1 Medical Center Dr. Lebanon, NH 03766	3131		1/24/22
Kori Costa	1 Medical Center Dr. Lebanon, NH 03766	3038		1.24.22
Kristen Grafenstein	1 Medical Center Dr. Lebanon, NH 03766	PHCY-01019		1/21/22
Laura Hackett	1 Medical Center Dr. Lebanon, NH 03766	3838		1/21/22
Caitlin Harper	1 Medical Center Dr. Lebanon, NH 03766	PHCY-04476		1/21/22
Katie Karkowski	1 Medical Center Dr. Lebanon, NH 03766	R2736		01/21/2022
Nicholas Nadeau	1 Medical Center Dr. Lebanon, NH 03766	R3155		1/24/22
<del>Chiugo Okeke</del>	<del>1 Medical Center Dr. Lebanon, NH 03766</del>	<del>PHCY-04499</del>	<del></del>	<del>01/24/22</del>
Alexandra Simms	1 Medical Center Dr. Lebanon, NH 03766	PHCY-01180		1/21/22
Gregory Wolfe	1 Medical Center Dr. Lebanon, NH 03766	4244		1/24/22

By signing this CPA, the practitioner(s) named below agree to all of the terms and conditions of this CPA with the named pharmacist(s) and patient who are also signing the CPA.

1. Practitioner name, address, NH license, signature, and date:

Practitioner Name	Address	NH License	Signature	Date
Elizabeth Bengtson	1 Medical Center Dr. Lebanon, NH 03766	10927		1/25/22
Marc Gautier	1 Medical Center Dr. Lebanon, NH 03766	10784		1/24/22
Christi Hayes	1 Medical Center Dr. Lebanon, NH 03766	17166		1/24/22
John Hill	1 Medical Center Dr. Lebanon, NH 03766	11829		1/25/22

\* please see page 12 for additional signatures

Frederick Lansigan	1 Medical Center Dr. Lebanon, NH 03766	14513		1/24/22
Christopher Lowrey	1 Medical Center Dr. Lebanon, NH 03766	8873		1/24/22
Kenneth Meehan	1 Medical Center Dr. Lebanon, NH 03766	8825		1/24/22
Parth Shah	1 Medical Center Dr. Lebanon, NH 03766	19608		1/24/22
Matthew Sullivan	1 Medical Center Dr. Lebanon, NH 03766	17663		1/24/22
Swaroop Yerrabothala	1 Medical Center Dr. Lebanon, NH 03766	15736		1/24/22

### Patient Summary, Benefits, and Signature

As discussed in the previous sections of this CPA, you and your practitioner have decided to seek additional healthcare support with the use of a Collaborative Pharmacy Practice Agreement. This CPA allows the pharmacist(s) named on the previous page to assist in improving your treatment outcomes for prevention of infection, graft-versus-host disease (GVHD), seizures, and veno-occlusive disease (VOD) through a combination of medical, educational, and follow-up interventions as described in this CPA. The pharmacist will work closely with your practitioner in order to ensure your goals and health care needs are met.

The pharmacist's responsibilities to you (and your caretaker), in conjunction with your practitioner are as follows:

- Educate on prescribed medications including dose, frequency, and common side effects;
- Help you recognize the importance and purpose of your medications by teaching you about how your medications work;
- Help identify and resolve medication related problems, for example drug-related side effects;
- Adjust medications as necessary (for example discontinue, start, change a dose, or add a new medication) to optimize your outcomes;
- Answer any questions you may have concerning your medication therapy.

As a Dartmouth-Hitchcock patient, we want you to be a part of the decisions made in your care. By signing this CPA, the named patient consents to being in this Collaborative Pharmacy Practice Agreement with the named pharmacist(s) and practitioner and signifies agreement with the following statements:

- A copy of the CPA and supporting guidelines have been given to me and sufficient time has been provided to me to review the documents;
- The benefits and risks of the CPA have been explained to me;
- I understand I have the right to terminate this CPA at any time;
- I have been given all the information I asked for about the CPA;
- I was given time to ask questions about the CPA and all of my questions were answered satisfactorily;
- I have read and understood this CPA and consent to be part of the CPA.

Patient's signature: \_\_\_\_\_

Patient's full name (printed): \_\_\_\_\_

Patient's address: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_

Date signed: \_\_\_\_\_

If the patient is not able to consent for her/himself complete the following:

Legally responsible person's name: \_\_\_\_\_

Relationship to patient (state whether Legal Guardian, Agent under Durable Power of Attorney for Healthcare): \_\_\_\_\_

Date signed: \_\_\_\_\_

If an interpreter was used:

Interpreter's name: \_\_\_\_\_

Interpreter's signature: \_\_\_\_\_

Commercial service name: \_\_\_\_\_

Date signed: \_\_\_\_\_

NH BOP Submission Date: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Completed Annual Review Date: \_\_\_\_\_

Next Renewal Date: \_\_\_\_\_

## Appendix A: Tables

Table 1: Disease State and Quality Performance Metrics

<b>Disease State</b>	<b>Quality Performance Metrics</b>
Supportive care for patients undergoing HCT	Number of patients enrolled
	Number of patients who opted out
	Number of patient encounters with the pharmacist
	From a random sample of 25% of patients enrolled in the CPA, a clinical pharmacist will assess the following:

	<ul style="list-style-type: none"> <li>• Amount of provider time saved per encounter measured as the amount of time the pharmacist spent</li> <li>• Number of prescriptions written per encounter</li> <li>• Number of interventions made per encounter</li> <li>• Appropriateness of the interventions made by the pharmacist and quality of the documentation</li> </ul>
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Table 2: Practice guidelines are adapted from the following:

Disease State	National Guideline	Reference Link
Prophylaxis of infections for HCT patients	Guidelines for Preventing Infectious Complications among Hematopoietic Cell Transplantation Recipients: A Global Perspective	<a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3103296/pdf/main.pdf">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3103296/pdf/main.pdf</a>
Seizure prophylaxis	American Society for Transplantation and Cellular Therapy Consensus Grading for Cytokine Release Syndrome and Neurologic Toxicity Associated with Immune Effector Cells	<a href="https://pubmed.ncbi.nlm.nih.gov/30592986/">https://pubmed.ncbi.nlm.nih.gov/30592986/</a>
	National Comprehensive Cancer Network Management of Immunotherapy-Related Toxicities	<a href="https://www.nccn.org/professionals/physician_gls/pdf/immunotherapy.pdf">https://www.nccn.org/professionals/physician_gls/pdf/immunotherapy.pdf</a>
GVHD prophylaxis	Prophylaxis and treatment of GVHD after allogeneic haematopoietic SCT: a survey of center strategies by the European Group for Blood and Marrow Transplantation.	<a href="https://doi.org/10.1038/bmt.2012.45">https://doi.org/10.1038/bmt.2012.45</a>
	Prophylaxis and management of graft versus host disease after stem-cell transplantation for haematological malignancies: updated consensus recommendations of the European Society for Blood and Marrow Transplantation.	<a href="https://www.clinicalkey.com/service/content/pdf/watermarked/1-s2.0-S235230261930256X.pdf?locale=en_US&amp;searchindex=">https://www.clinicalkey.com/service/content/pdf/watermarked/1-s2.0-S235230261930256X.pdf?locale=en_US&amp;searchindex=</a>
VOD prophylaxis	BCSH/BSBMT guideline: diagnosis and management of veno-occlusive disease (sinusoidal obstruction syndrome) following haematopoietic stem cell transplantation	<a href="https://onlinelibrary.wiley.com/doi/epdf/10.1111/bjh.12558">https://onlinelibrary.wiley.com/doi/epdf/10.1111/bjh.12558</a>

Table 3: Medications

Drug Class	Medication: Generic (Brand)	Initiate	Modify	Discontinue	Refill
Antiviral agents	Acyclovir oral capsule (Zovirax)	✓	✓	✓	✓
	Acyclovir oral tablet (Zovirax)	✓	✓	✓	✓

	Acyclovir oral suspension (Zovirax)	✓	✓	✓	✓
	Valacyclovir oral tablet (Valtrex)	✓	✓	✓	✓
	Valganciclovir oral tablet (Valcyte)	✓	✓	✓	✓
	Valganciclovir oral solution (Valcyte)	✓	✓	✓	✓
	Letermovir oral tablet (Prevymis)	✓	✓	✓	✓
Antibacterial agents	Sulfamethoxazole/trimethoprim oral tablet (Bactrim or Bactrim DS)	✓	✓	✓	✓
	Sulfamethoxazole/trimethoprim oral suspension (Bactrim or Bactrim DS)	✓	✓	✓	✓
	Atovaquone oral suspension (Mepron)	✓	✓	✓	✓
	Pentamidine injection (Pentam)	✓	✓	✓	✓
	Pentamidine inhalation (Nebupent)	✓	✓	✓	✓
	Dapsone oral tablet	✓	✓	✓	✓
	Levofloxacin oral solution	✓	✓	✓	✓
	Levofloxacin oral tablet (Levaquin)	✓	✓	✓	✓
	Ciprofloxacin oral suspension (Cipro)	✓	✓	✓	✓
	Ciprofloxacin oral tablet (Cipro)	✓	✓	✓	✓
	Ciprofloxacin oral tablet ER	✓	✓	✓	✓
	Amoxicillin/Clavulanate oral suspension (Augmentin)	✓	✓	✓	✓
	Amoxicillin/Clavulanate oral tablet (Augmentin)	✓	✓	✓	✓
	Amoxicillin/Clavulanate oral tablet chewable	✓	✓	✓	✓
	Amoxicillin/Clavulanate oral ER tablet (Augmentin XR)	✓	✓	✓	✓
	Cefpodoxime oral suspension	✓	✓	✓	✓
	Cefpodoxime oral tablet	✓	✓	✓	✓
	Azithromycin oral tablet (Zithromax)	✓	✓	✓	✓
	Azithromycin oral suspension (Zithromax)	✓	✓	✓	✓

	Azithromycin oral packet (Zithromax)	✓	✓	✓	✓
	Vancomycin (Vancocin) oral capsule	✓	✓	✓	✓
	Vancomycin (Firvanq) oral solution	✓	✓	✓	✓
	Fidaxomicin (Difcid) oral tablet	✓	✓	✓	✓
	Fidaxomicin (Difcid) oral suspension	✓	✓	✓	✓
Antifungal agents	Fluconazole oral suspension (Diflucan)	✓	✓	✓	✓
	Fluconazole oral tablet (Diflucan)	✓	✓	✓	✓
	Posaconazole oral suspension (Noxafil)	✓	✓	✓	✓
	Posaconazole oral tablet DR (Noxafil)	✓	✓	✓	✓
	Voriconazole oral suspension (Vfend)	✓	✓	✓	✓
	Voriconazole oral tablet (Vfend)	✓	✓	✓	✓
	Itraconazole oral capsule (Sporanox)	✓	✓	✓	✓
	Itraconazole oral solution (Sporanox)	✓	✓	✓	✓
	Isavuconazonium oral capsule (Cresemba)	✓	✓	✓	✓
Immunosuppressive agents	Tacrolimus oral capsule (Prograf)	✓	✓	✓	✓
	Tacrolimus oral capsule ER (Astagraf XL)	✓	✓	✓	✓
	Tacrolimus oral packet (Prograf)	✓	✓	✓	✓
	Sirolimus oral solution (Rapamune)	✓	✓	✓	✓
	Sirolimus oral tablet (Rapamune)	✓	✓	✓	✓
	Cyclosporine oral capsule (Neoral/Gengraf/SandIMMUNE)	✓	✓	✓	✓
	Cyclosporine oral solution (Neoral/Gengraf)	✓	✓	✓	✓
	Mycophenolate mofetil oral capsule (CellCept)	✓	✓	✓	✓
	Mycophenolate mofetil oral suspension (CellCept)	✓	✓	✓	✓

	Mycophenolate mofetil oral tablet (CellCept)	✓	✓	✓	✓
	Mycophenolate mofetil oral tablet delayed release (Myfortic)	✓	✓	✓	✓
Anticonvulsant	Levetiracetam oral solution (Keppra)	✓	✓	✓	✓
	Levetiracetam oral tablet (keppra)	✓	✓	✓	✓
	Levetiracetam oral disintegrating tablet (Spritam)	✓	✓	✓	✓
	Levetiracetam oral tablet ER (Keppra XR)	✓	✓	✓	✓
	Phenytoin oral capsule (Dilantin)	✓	✓	✓	✓
	Phenytoin oral suspension (Dilantin)	✓	✓	✓	✓
	Phenytoin oral tablet chewable (Dilantin Infatabs)	✓	✓	✓	✓
Anti VOD	Ursodiol oral capsule (Actigall/Reltone)	✓	✓	✓	✓
	Ursodiol oral tablet (Urso)	✓	✓	✓	✓
Colony stimulating factors	filgrastim-sndz (Zarxio)	✓	✓	✓	✓
	tbo-filgrastim (Granix)	✓	✓	✓	✓
	filgrastim-aafi (Nivestym)	✓	✓	✓	✓
	Filgrastim (Neupogen)	✓	✓	✓	✓
Electrolytes	Magnesium oxide oral capsule	✓	✓	✓	✓
	Magnesium oxide oral packet	✓	✓	✓	✓
	Magnesium oxide oral tablet	✓	✓	✓	✓
	Magnesium plus soy protein oral tablet (MagPro)	✓	✓	✓	✓

Table 4: Laboratory Tests

Frequency	Test
As needed to guide appropriate dosing up to a maximum of once daily	Tacrolimus level
As needed to guide appropriate dosing up to a maximum of once daily	Cyclosporine level
As needed to guide appropriate dosing up to a maximum of once daily	Sirolimus level

HCT CPA New Practitioner Addendum Signature page

1. Pharmacist name, address, NH license, signature, and date:

Pharmacist Name	Address	NH License	Signature	Date
Drye, Melissa	1 Medical Center Dr. Lebanon, NH 03766	3628	<i>Melissa Drye</i>	5/2/22
Nero, Ricki	1 Medical Center Dr. Lebanon, NH 03766	PHCY-01353	<i>Ricki Nero</i>	8/24/22
Simpson, Morgan	1 Medical Center Dr. Lebanon, NH 03766	PHCY-01154	<i>Morgan Simpson</i>	9-30-22
Breiner, Samuel	1 Medical Center Dr. Lebanon, NH 03766	PHCY-01353	<i>Samuel Breiner</i>	9/1/22
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			

By signing this CPA, the practitioner(s) named below agree to all of the terms and conditions of this CPA with the named pharmacist(s) and patient who are also signing the CPA.

1. Practitioner name, address, NH license, signature, and date:

Practitioner Name	Address	NH License	Signature	Date
Preis, Meir	1 Medical Center Dr. Lebanon, NH 03766	15768	<i>Meir Preis</i>	5/21/2022
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			
	1 Medical Center Dr. Lebanon, NH 03766			