

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
		Samantha	Ann	Hoffberg
Mailing Address				
PO Box 526 Hartland, VT 05048				
NH Pharmacist License Number	Home or Cell Phone #	Work Phone #	E-mail Address (Must be entered to receive your updated license with CPP endorsement):	
PHCY-01377	(603) 247-2515	(603) 542-1805	Samm42890@aol.com	

2. CURRENT PHARMACY EMPLOYMENT ASSOCIATED WITH THIS COLLABORATIVE AGREEMENT
Name of NH Pharmacy
Valley Regional Hospital
Complete Mailing & Physical Address of NH Pharmacy
243 Elm Street Claremont, NH 07743

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>Liberty Insurance Underwriters 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 be completed every 2 years</u> , from (please check one):
<input checked="" type="checkbox"/> American Heart Association <input type="checkbox"/> American Red Cross <input type="checkbox"/> Not Applicable - I Do Not Administer Vaccines
* <u>If administering vaccines</u> , you <u>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 checked="" type="checkbox"/> Anticoagulation <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension
<input type="checkbox"/> Other (Describe): _____

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

- Received PharmD from MCPHS University, 2022
- Completed Medication Therapy Management Services Certificate, April 2021 (APHA)
- Completed Ambulatory Care APPE rotation, 2022
- Worked in direct patient care pharmacy settings since 2012
- Trained on point of care INR monitor


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:  Date: 9/14/22

7. EMPLOYER ATTESTATION STATEMENT:

As owner / chief administrative officer of Valley Regional 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 318:38 and Ph 704.11(d).

Signature Of Organization Representative:  Title: Director of Pharmacy Date: 15 Sept 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').

ADVANCED CARDIOVASCULAR LIFE SUPPORT

HeartCode® Complete ACLS Provider



American
Heart
Association.

Samantha Hoffberg

has successfully completed the cognitive and skills evaluations
in accordance with the curriculum of the American Heart Association
Advanced Cardiovascular Life Support (ACLS) Program.

Issue Date

08/05/2022

Renew By

08/31/2024

HeartCode Complete Location

Valley Regional Hospital

eCard Code

1iv118u6kyz51qzwhzurxfnz

The HeartCode Program is provided by:
American Heart Association
RQIQuestions@heart.org

QR Code



To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to
https://certificates.nq1stop.com/certificates/us/verify_certificate

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BASIC LIFE SUPPORT

HeartCode® Complete BLS Provider



American
Heart
Association.

Samantha Hoffberg

**has successfully completed the cognitive and skills evaluations
in accordance with the curriculum of the American Heart Association
Basic Life Support (CPR and AED) Program.**

Issue Date

08/05/2022

Renew By

08/31/2024

HeartCode Complete Location

Valley Regional Hospital

eCard Code

qe3tpg1f1dthyzeiurispuiu

The HeartCode Program is provided by:

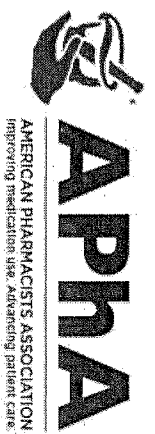
American Heart Association
RQIQuestions@heart.org

QR Code



To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to
https://certificates.rq1stop.com/certificates/us/verify_certificate

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Pharmacy-Based Immunization Delivery Certificate of Achievement

This acknowledges that

Samantha Hoffberg

has successfully completed the *APHA Pharmacy-Based Immunization Delivery* certificate training program focusing on the knowledge and skills associated with vaccine information and administration. The training associated with this APHA Certificate of Achievement is based on current immunization standards and recommendations at the time of training. It is the responsibility of the immunizer to engage in continuing professional development and education to meet the immunization standards and practice expectations set forth by the immunizer's state board of pharmacy and/or the policies and procedures of the organization that employs the immunizer. This Certificate of Achievement does not expire, but in accordance with existing immunization standards, immunizers should maintain and have accessible proof of current continuing professional development in the area of immunizations and a certification in Cardiopulmonary Resuscitation (CPR) or Basic Cardiac Life Support (BCLS).

Date of Issue: 8/14/2020

ACPE Information:

Practice-Based Activity
Home Study 12 hours of CPE credit
Live Seminar 8 hours of CPE credit



A handwritten signature in black ink, appearing to read 'T. Menighan', is written over a horizontal line.

Thomas E. Menighan, BSRPharm, MBA, SCD(Hon), FAPHA
Executive Vice President and CEO
American Pharmacists Association



Valley Regional Healthcare

Ambulatory Pharmacist
Collaborative Practice
Agreement

Samantha Hoffberg, PharmD

Anticoagulation Management

Valley Regional Hospital 241 Elm St Claremont, NH 03743

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Introduction

1. This Collaborative Pharmacy Practice Agreement (CPA) follows the New Hampshire Board of Pharmacy (NH BOP) **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 provider signing this CPA, as listed in **Appendix A**.
2. By entering into this CPA, each Valley Regional Hospital (VRH) pharmacist signing below (the “pharmacist”) is authorized to provide disease state management services as described in this CPA for the specified chronic disease state identified on the cover page.

Purpose

In order to enhance the quality of patient care and improve patient access, the pharmacist will complement the care provided by the providers, for the specific disease state named in this CPA. Upon receipt of a patient and disease-state specific referral order, the pharmacist will order appropriate and necessary labs, authorize appropriate medication refills, implement, modify, or discontinue medications, facilitate referrals, and provide education as appropriate for the referred patient.

Goals

1. To improve the patient’s overall health and, specifically, the disease state for which the patient was referred by providing evidence-based, patient-centered care for optimal drug therapy results and improved patient outcomes;
2. To increase patient and provider access;
3. To provide cost-effective care to the patient; and
4. To improve patient/caregiver self-management skills and adherence to drug therapy related to the referred disease state.

Services

1. Under this CPA, the pharmacist is authorized to initiate, modify, and discontinue the specific drugs listed in **Appendix B, Table 1**.

2. 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 chronic disease state and may vary from days to months.
3. The pharmacist will provide services to the patient under this 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").
4. 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 clinic, size of the patient population, the patient and the availability of HIPAA compliant space in which to provide services to the patient at the applicable division site.

Scope

- General

This CPA applies to the practice site included under the umbrella of care and administration of Valley Regional Hospital. The practice site details below:

1. Associates in Medicine
241 Elm St
Claremont, NH 03743

This CPA authorizes the named pharmacist to monitor and assess the patient's chronic disease state by:

1. Interviewing the patient and gathering health information that may include, but is not limited to the following:
 - a. Medical and drug history
 - b. Social and family history
 - c. Lifestyle history
 - d. Self-monitoring results (e.g. blood pressure, blood glucose, etc.)
 - e. Review of recommended exams (e.g. eye, foot, pulmonary function tests, etc.)
 - f. Vaccination history
 - g. Drug allergies and intolerances
 - h. Prescription insurance
2. Performing physical assessments including the use of devices (e.g. vitals, point of care tests);
3. Ordering and assessing the drug therapies through the utilization of appropriate laboratory monitoring, as detailed in Appendix B.
4. Initiating, refilling, modifying and/or discontinuing the medications detailed in **Appendix B, Tables 1**

- **Drug Therapy Management**

Decisions regarding modifications of the patient's drug therapy and selection of drug therapy will be consistent with the metrics based upon disease-state specific best practice guidelines detailed in **Appendix D** and/or Valley Regional Hospital Policies detailed in **Appendix E**. The specific goals for the patient may differ based upon the patient's specific needs and condition and will be specified in the patient's chart. If the pharmacist recommends altering a goal of the drug therapy based on the pharmacist's clinical judgement, the pharmacist will document his/her recommendation change in the electronic medical record (eMR), which will be sent to the ordering provider within 72 hours for co-signature.

1. The pharmacist may order the laboratory tests listed as they pertain to the patient's specific medications and chronic disease state(s) (See appendix C)

- **Documentation and Record Keeping**

1. Documentation for each CPA visit with the patient will occur in the patient's eMR. The pharmacist will have access to the patient's eMR and may access the patient's record as appropriate.
2. A summary of each visit containing all drug therapy initiations, modifications, discontinuances and refills and individualized patient care plans will be documented by the pharmacist in the patient's eMR and routed to the provider no later than three (3) days after the patient's visit.
3. A copy of this CPA and associated protocols will be kept on file and be available on request. A copy will be retained at the pharmacist's place of practice.
4. If the CPA is terminated by either the pharmacist or provider, the patient must receive prompt written notification with details as to allow for uninterrupted continuation of their therapy management program.

- **Communication**

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 provider. Notification by the pharmacist to the provider 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. Provider modifications 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 provider or promptly will contact the provider for additional information/recommendations.

- Quality Assurance

1. An annual review of the CPA will be performed by the pharmacist to determine whether edits to the document need to be made. If an edit is warranted, the pharmacist will notify the patient and the attending provider. A material amendment to the CPA must be signed by the pharmacist and the providers(s) to reflect any changes to or under this CPA. No changes will be effective until the amendment or a new CPA is signed by all applicable parties. The pharmacist will provide written or electronic notification in accordance with applicable law and rules to the NH BOP within 15 days of the changes being 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 or as otherwise instructed.
3. The CPA will be renewed at a minimum of two years.
4. The pharmacist will maintain the qualifications to participate in the CPA, as required under applicable law and rules.
5. The pharmacist will maintain basic cardiopulmonary resuscitation (CPR), from a nationally recognized organization and documentation of this certification.
6. The patient's chronic disease states goals will be continually monitored for improvement as part of quality performance metrics detailed in **Appendix F**.
7. Neither the provider 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, product changes, or the ordering of tests or services.

By signing this CPA, the pharmacist named below agrees to all of the terms and conditions of this CPA with the named provider(s) who are signing below and patients with signed consent forms.

1. Pharmacist signature and date:




Samantha Hoffberg, PharmD

9/14/22

Date

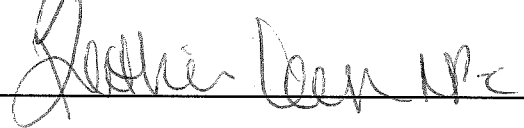
Appendix A: Pharmacist Collaborative Practice Provider Signature Page



Juliann Barrett, DO (Medical Director)

6/27/22

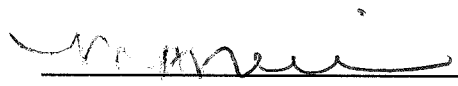
Date



Katherine Cooper, APRN

6/28/22

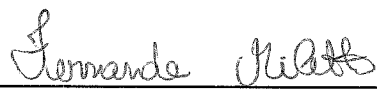
Date



Marcella Meier, APRN

6/28/2022

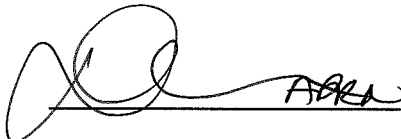
Date



Fernanda Miletto, MD

6/27/2022

Date



Jillian Rafter, APRN

6/27/2022

Date

Appendix B: Pharmacological Agents for Anticoagulation

- Coumadin®, Jantoven® (warfarin) – Modifying & Refilling
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Appendix C: Laboratory Monitoring Order

- Point of Care INR test
- PT/INR
- CBC

Appendix D: Practice Guidelines

- Antithrombotic Therapy for Atrial Fibrillation: CHEST Guideline and Expert Panel Report. Chest 2018 (updated as guidelines as updated)
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- American College of Cardiology's (ACC) ASCVD Risk Estimator Plus; <https://tools.acc.org/ASCVD-Risk-Estimator-Plus>

Appendix E: Quality Metrics: Anticoagulation

- Time in Therapeutic range (TTR)
- Sub-therapeutic INR
- Super-therapeutic INR



Valley Regional Healthcare

Ambulatory Pharmacist Collaborative Practice Agreement

Samantha Hoffberg, PharmD

Anticoagulation Management

Valley Regional Hospital 241 Elm St Claremont, NH 03743

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1. Pharmacist signature and date:

Samantha Hoffberg, PharmD

Date

Appendix A: Pharmacist Collaborative Practice Provider Signature Page

Juliann Barrett, DO (Medical Director) _____
Date

Katherine Cooper, APRN _____
Date

Marcella Meier, APRN _____
Date

Fernanda Miletto, MD _____
Date

Jilian Rafter, APRN _____
Date

Robert Dayer, MD _____
Date

Richard Cappello _____
Date

Appendix B: Pharmacological Agents for Anticoagulation

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- Eliquis® (apixaban) – Modifying & Refilling
- Xarelto® (rivaroxabn) – Modifying & Refilling
- Lovenox® (enoxaparin) – Start, Stop, Modifying, & Refilling for bridging purposes only

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- Antithrombotic Therapy for VTE Disease: CHEST Guideline and Expert Panel Report. Chest 2016
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<https://tools.acc.org/ASCVD-Risk-Estimator-Plus>

Appendix E: Quality Metrics: Anticoagulation

- Time in Therapeutic range (TTR)
- Sub-therapeutic INR
- Super-therapeutic INR

Pharmacist Collaborative Practice Provider List

Valley Primary Care

7 Dunning St, Claremont, NH 03743

Juliann Barrett, DO (Medical Director)

NH License 18303

Marcella Meier, APRN

NH License 080523-23

Jillian Rafter, APRN

NH License 056514-23

Associates in Medicine

241 Elm St, Claremont, NH 03743

Fernanda Miletto, MD

NH License 19657

Katherine Cooper, APRN

NH License 071563-23

**ANTICOAGULATION CLINIC
VALLEY REGIONAL HEALTHCARE
243 ELM ST
CLAREMONT, NH. 03743
PharmD**

You have been referred by your primary care provider to the Anticoagulation Clinic (Clinic) at Valley Regional Healthcare. The Clinic is a partnership between your primary care provider (PCP) and _____, Pharm.D, the pharmacy practitioner who provides this service to the clinic. Your PCP has documented why you are on warfarin, what your goal INR should be, and how long you should remain on the medication.

This document is an agreement between _____
(Print name and DOB)

and the Anticoagulation clinic (Clinic) at Valley Regional Healthcare. The purpose of this agreement is to assure you receive the best care and to help you get the most benefit from this medication.

As a client you have the right to be treated with respect and dignity, to privacy, to make informed decisions for yourself and to know what is expected of you.

My responsibilities as a client are:

- To maintain a relationship with a doctor, or other primary care provider at Valley Regional Healthcare while I am enrolled in the Clinic
- To inform the Clinic personnel if I change my contact information
- To provide the Clinic with a phone number where I can be contacted. I give permission for the Anticoagulation staff to leave pertinent information on my answering machine.
 - If the Clinic calls me, I will return the call as soon as possible
- To come to all scheduled clinic appointments
 - The clinic appointments are 20 minutes; therefore if you arrive 5 minutes or more late, the pharmacist reserves the right to ask you to re-schedule
 - To call to reschedule your appointment if a conflict arises within 3 days if possible
- To take my warfarin (COUMADIN®) as instructed
- To inform the Clinic of all new medications, both prescribed, over-the-counter and herbal
- To inform the Clinic of any scheduled dental/surgical procedures and if I need to stop taking my warfarin for any reason
- If I drink alcohol, I agree to use it in moderation and with consistency and report any changes in the amount I drink to the Clinic
- Female Patients: I understand anticoagulation therapy during pregnancy can be harmful to developing babies. I am not currently pregnant and will immediately inform the Clinic if I get pregnant.
- I will contact the Clinic (or seek medical treatment during off hours) if I have problems such as:
 - Bleeding from the gums or nose that does not stop
 - Red or brown urine
 - Red or black tarry stools
 - Vomiting blood or anything that looks like “old coffee grounds”
 - Cuts that do not stop bleeding or bruises that grow bigger

- Very heavy menstrual bleeding or other vaginal bleeding
- Fall and hit my head
- I will seek immediate medical treatment if I have ANY unexplained bleeding
- I will call the Clinic if I do not get instructions 24 hours after having a lab/blood test

I understand that I am taking a medicine that must be followed closely in order to protect me from complications. I also understand that noncompliance with any of the above can result in serious health risks. If my INR is too high, bleeding and hemorrhage can occur. If my INR is too low, blood clots can form that can lead to heart attack, stroke, or blood clots in my lungs.

I understand that noncompliance with any of the above guidelines may cause me to be terminated from the Anticoagulation Clinic. This termination does not mean termination with your PCP; however he/she will be informed and acknowledges and agrees with this document.

I understand that my health care provider has referred me to the Anticoagulation Clinic, which offers oversight of my warfarin therapy by a licensed pharmacist in partnership with my provider. I have read the above information and understand both my rights and responsibilities as a client in this program.

My signature below constitutes my understanding of the above guidelines.

Signature _____ Date _____
(Patient's signature)

The pharmacist's responsibilities in the clinic are to do the following:

- Carry out your doctor's request by monitoring and making appropriate changes to your warfarin dose
- Educate you about the appropriate use of warfarin, including drug-drug and drug-food interactions with this medication
- Observe for any complications of therapy, including drug interactions, and report these findings to your primary care provider
- Communicate back to your PCP the outcome of each clinic appointment
- Schedule appropriate follow-up appointments for INR monitoring
- Answer any questions you may have concerning your warfarin therapy

MEMORANDUM OF INSURANCE	Date Issued 08/19/2022
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Producer Mercer Consumer, a service of Mercer Health & Benefits Administration LLC P.O. Box 14576 Des Moines, IA 50306-3576 1-800-375-2764	This memorandum is issued as a matter of information only and confers no rights upon the holder. This memorandum does not amend, extend or alter the coverages afforded by the Certificate listed below.
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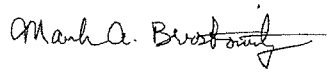
	Company Affording Coverage
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Insured Samantha A Hoffberg 11 Quechee Rd HARTLAND, VT 05048	Liberty Insurance Underwriters Inc.
--	-------------------------------------

This is to certify that the Certificate listed below has been issued to the insured named above for the policy period indicated, notwithstanding any requirement, term or condition of any contract or other document with respect to which this memorandum may be issued or may pertain, the insurance afforded by the Certificate described herein is subject to all the terms, exclusions and conditions of such Certificate. The limits shown may have been reduced by paid claims.
 The Memorandum of Insurance and verification of payment are your evidence of coverage. No coverage is afforded unless the premium is successfully paid in full.

Type of Insurance	Certificate Number	Effective Date	Expiration Date	Limits	
Professional Liability Pharmacist E Pharmacist	AHY-110322610	08/22/2022	08/22/2023	Per Incident/ Occurrence	\$1,000,000
				Annual Aggregate	\$3,000,000

PROOF OF INSURANCE

Memorandum Holder: PROOF OF COVERAGE ONLY	Should the above describe Certificate be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the Memorandum Holder named to the left, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.
	Authorized Representative Mark Brostowitz
	



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Policy Title: Outpatient Pharmacist-managed Warfarin Monitoring Service

Policy Manual Name: Medication Management

Last Revised: 6/2021,

Purpose: To reduce the likelihood of patient harm associated with the use of anticoagulation therapy. To assist all Valley Regional Healthcare providers in achieving and maintaining therapeutic anticoagulation in a timely and consistent manner in patients receiving warfarin by:

- Evaluating individual patients' International Normalized Ratio (INR) results and adjusting warfarin to achieve and maintain therapeutic INR personalized to their needs
- Monitoring patients for potential factors that could alter warfarin response, such as changes in clinical conditions or concurrent medications.
- Providing detailed education to patients and/or caregivers about warfarin therapy
- Provide anticoagulation bridging when consulted to do so
- Assessing patients' response to therapy and identification of any possible complications related to warfarin therapy with specific attention to signs and symptoms.

Policy Scope: Pharmacy, Valley Regional Healthcare Outpatient Clinics

Policy: The Pharmacist will provide assistance to all Valley Regional Healthcare Primary Care providers in the management of patients receiving warfarin when consulted to do so. Pharmacists designated for the outpatient service will have specific training and knowledge in managing warfarin therapy, and will be designated specifically for this service.

Procedure:



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1. Eligible patients:

- Patients will be eligible for this program if a provider has requested they be scheduled to meet with the anticoagulation pharmacist. Documentation of this may be found in the patient's electronic record.
- Patients included in this protocol are adults 18 years of age or older.

2. Patients will be provided with drug therapy management services by the anticoagulation pharmacist. This service will include the initial evaluation, monitoring, dosing adjustment, education, and documentation in a standard visit format in the electronic patient record.

- Patients will be required to sign a contract between the patient and pharmacist that will outline expectations (see attached Warfarin clinic PATIENT CONSENT FORM_VRH)

The expectations of the Clinical Pharmacist are:

- Establish by review of the patient's problem list, and/or communication with the provider, the indication for use. Documentation of indication will be part of the patient's problem list in the electronic medical record. The INR goal is determined by this diagnosis, unless directed otherwise by the provider, or PCP (Primary care provider).
- Assume responsibility for assuring the patient's warfarin is dosed on a routine basis, as dictated by the current INR, potential for a drug interaction from an agent recently added to the patient's regimen, and known bleeding risk.
- Obtain adequate patient demographic, medical and medication history in order to identify factors that could affect response to warfarin therapy. Documentation of such factors will be entered into the electronic medical record as part of the anticoagulation visit.
- The pharmacist will always notify the referring provider, PCP or covering provider, when:
 - INR level is greater than 5.0
 - Any time clinically significant signs of thrombosis or bleeding are being reported
 - Any time further clarification of the clinical status of the patient is needed
- Each visit, document the following in the patient's electronic medical record:
 - Patient's date of birth
 - Any change in health since the last INR visit, including urgent or routine follow-up with the PCP
 - Any change in medication use, including OTC (over-the-counter), herbal, or prescription products



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- Any significant change in diet
- Any missed doses, or extra doses taken in error
- Any bleeding or bruising
- Any plans for travel that will require a sitting position for significant periods of time
- Drug allergy status
- Indication for anticoagulation
- INR
- Dose recommendation in response to INR
- Date of next appointment
- Any communication with the PCP that takes place in response to the INR value, or reports of physical complaints by the patient

In the event of the pharmacist absence, the pharmacist will communicate the coverage plan or the need for provider coverage.

Annually, the pharmacist must have on record signed consent from the patient agreeing to the monitoring of their warfarin therapy by that pharmacist. In addition, a yearly collaborative practice agreement will be signed by both the pharmacist and Valley Regional Healthcare primary care providers.

3. Expectations of the provider when delegating the authority to dose warfarin to the pharmacist-managed inpatient service:
 - Provider will state in the electronic medical record, the indication for warfarin and the target INR. Unless otherwise specified, the targeted INRs used to guide warfarin therapy will be those recommended by the most recent American College of Chest Physicians (ACCP) Consensus Conference on Antithrombotic Therapy
 - Provider/PCP will maintain all ability to order warfarin if desired
 - Provider is still responsible for the overall anticoagulation needs of the patient, however, the pharmacist will assist the provider in this regard
 - Provider should communicate directly with the pharmacist anytime they are concerned with how the pharmacist is managing warfarin therapy for a patient
 - Provider is expected to communicate to the pharmacist any pressing clinical concerns they have that could contribute to the pharmacist's clinical decision making
 - The referring provider/PCP must sign an annual contract with the anticoagulation pharmacist granting permission for that specific pharmacist to monitor and dose warfarin therapy for their patient



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4. Point of care (POC) testing:

- The POC testing will be performed in the outpatient setting
- INR results will be acted on within the limits of the manufacturer
- Venous draws for INRs and/or complete blood counts (CBC) will be requested if:
 - i. INR is outside the limits of the manufacturer
 - ii. At the request of the provider
 - iii. At the request of the pharmacist with supporting clinical judgement to include but limited to patient reporting of spontaneous bruising, active bleeding, patient reports shortness of breath, weakness, fatigue and/or leg swelling

GUIDELINES:

**Use INR goals set by cardiothoracic surgeon/provider if available, otherwise use below guidelines.*

- Targeted INRs are:

Indication	INR
Prophylaxis of venous thrombosis	2 - 3
Treatment of deep vein thrombosis/pulmonary embolism	2 - 3
Prevention of systemic embolism:	
Tissue heart valves	2 - 3
Acute myocardial infarction (to prevent systemic embolism)	2 - 3
AMI (to prevent recurrent MI)	2.5 - 3.5
Valvular heart disease	2 - 3
Atrial fibrillation	2 - 3
Bileaflet mechanical valve in aortic position	2 - 3
Mechanical prosthetic valves (high risk)	2.5 - 3.5
Presence of Lupus Anticoagulation or Antiphospholipid Antibodies	2.0-3.0
Activated protein C & S deficiency	2 - 3

- **Dosing for warfarin naïve patient:**

- New patient starting doses of warfarin will be those listed in the following table:

Patient Condition	Warfarin Dose/per day
69 years or younger	5 mg
DVT prophylaxis following joint replacement	5 mg
70 years or older	4 mg



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Impaired nutritional status	4 mg
Acute or exacerbation of Congestive Heart Failure	4 mg
High risk of bleeding	4 mg

- o Pharmacist will adjust warfarin according to the following chart, unless clinical judgment advises otherwise (e.g., an interacting medication is ordered, or dose response is not what would routinely be expected).

Day of warfarin Therapy	INR Value	Dose
Day two	<ul style="list-style-type: none"> • Less than 1.5 • 1.5 – 1.9 • 2 – 2.5 • 2.5 - 3 • Greater than 3 	<ul style="list-style-type: none"> • 5 mg • 2.5 mg • 1 - 2.5 mg • No dose • No dose
Day three	<ul style="list-style-type: none"> • Less than 1.5 • 1.5 – 1.9 • 2 – 2.5 • 2.5 - 3 • Greater than 3 	<ul style="list-style-type: none"> • 5 – 7.5 mg • 5-10mg if >120kg • 2.5 – 5 mg • 0 - 2.5 mg • 0 – 2.5 mg • No dose
Day four	<ul style="list-style-type: none"> • Less than 1.5 • 1.5 – 1.9 • 2 – 2.5 • 2.5 - 3 • Greater than 3 	<ul style="list-style-type: none"> • 10 mg • 5 – 7.5 mg • 0 - 5 mg • 0 - 5 mg • No dose
Day five	<ul style="list-style-type: none"> • Less than 1.5 • 1.5 – 1.9 • 2 – 2.5 • 2.5 - 3 • 3 – 3.5 • Greater 3.5 	<ul style="list-style-type: none"> • 10 mg • 7.5 - 10 mg • 0 - 5 mg • 0 - 5 mg • No dose • No dose
Day six	<ul style="list-style-type: none"> • Less than 1.5 • 1.5 – 1.9 • 2 – 3 • 3 – 3.5 • Greater than 3 	<ul style="list-style-type: none"> • 7.5 – 12.5 mg • 5 – 10 mg • 0 – 7.5 mg • No dose • No dose

Dosing for warfarin maintenance patients:



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- After the first week of warfarin, or for patients on maintenance warfarin, the pharmacist will adjust the **weekly dose** according to the following chart, unless clinical judgement advises otherwise (e.g. interacting medication is ordered, or dose response is not what would routinely be expected) : use column that reflects desired INR goal range.

INR	2 - 3	2.5 – 3.5
< 1.5	Increase weekly dose by 5-15%	Increase weekly dose by 15-20%
1.5 - 2	Increase weekly dose by 5-10%	Increase weekly dose by 5-15%
2 – 2.5	Therapeutic: no change	Increase weekly dose by 5-10%
2.5 - 3	Therapeutic: no change	Therapeutic: no change
3 – 3.5	Decrease weekly dose by 5-10%	Therapeutic: no change
3.5 - 4	Hold one dose. Decrease weekly dose by 10-15%	Decrease weekly dose by 5 - 15%
4 - 5	Hold two doses. Decrease weekly dose by 10-15%	Hold one – two doses. Decrease weekly dose by 5-15%
> 5	<ul style="list-style-type: none">• Hold warfarin until INR is therapeutic• Recheck PT/INR within two days via POC or lab draw• Assess for signs of bleeding, including: nosebleeds, bleeding from gums, unusual bleeding or bruising, vomiting red/coffee ground material, red or tarry stools, red or dark brown urine• Consult with provider	

Monitoring of Treatment plan:

- The frequency of INR monitoring will be determined by the pharmacist, based on the INR and clinical judgment (e.g., an interacting medication is prescribed). The following guideline will be used.
 - INR therapeutic: repeat INR in four weeks to six weeks via POC testing or lab draw



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- INR > 4; repeat INR within one to two days after medication adjustment via POC testing or lab draw; contact PCP for guidance if needed.
- INR < 1.5; repeat INR in one to seven days after medication adjustment via POC testing and lab draw
- INR > 1.5 < 2.0; repeat INR in one to two weeks, after medication adjustment via POC testing or lab draw, or sooner if patient is new to therapy

PATIENT / FAMILY TEACHING:

Outpatient education will focus on

- Assessment of:
 - Factors that may influence patient or family's ability to learn
 - Preference for learning
 - Readiness to learn
- Education on:
 - Rationale and action of warfarin therapy
 - Purpose for blood testing and interpretation of INR
 - Warfarin administration
 - Other medication use and current medication therapy
 - Dietary considerations
 - Signs / symptoms of bleeding and actions to take
 - Safety measures the patient should take to avoid harm
 - Each patient will be provided with written information to reinforce the verbal information provided

QUALIFICATIONS OF PERSONNEL

Warfarin therapy should be provided by a licensed pharmacist possessing core competency related to anticoagulation therapy. Because anticoagulant therapy is complex and associated with substantial risks, additional training is recommended in the following core domains for establishing competency:

- Applied physiology and pathophysiology of thromboembolic disorders – working knowledge regarding the normal physiological processes of hemostasis and thrombosis, and the etiology, risk factors, and clinical manifestations of pathologic thrombus formation
- Patient assessment and management – knowledge, skills and competencies to manage and monitor patients on anticoagulant therapy, including the ability to assess the efficacy and toxicity of the prescribed anticoagulant treatment, determine whether the therapeutic goals have been achieved, and identify patient-related variable that affect therapy



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- Patient education – ability to provide patient education that is tailored to patients' specific needs to promote safety, enhance adherence, and positively affect clinical outcomes; perform an educational assessment; develop an educational plan, and document the educational activities in the patient's medical record
- Applied pharmacology of antithrombotic agents – in-depth knowledge regarding the pharmacologic properties of warfarin

Competency can be demonstrated by:

- Documentation of a minimum of five hours of ACPE-certified continuing education per year in anticoagulation therapy and medication therapy management.
- In addition it is highly recommended that the anticoagulation pharmacist become certified as an anticoagulation specialist. In lieu of specific certification, the designation of Board Certified Pharmacotherapy Specialist, or Board Certified Ambulatory Care Pharmacist, will be considered equivalent.

Reference(s):

CHEST 2012; 141(2)(Suppl): e152s-e184s

Attachment: Warfarin clinic PATIENT CONSENT FORM_VRH, WARFARIN CLINIC_VRH_contract

Cross Reference(s)

1. CLIA Waived and Point of Care Testing (POCT)
2. Prothrombin Time (PT/INR) Point of Care Testing

**ANTICOAGULATION CLINIC
VALLEY REGIONAL HEALTHCARE
243 ELM ST
CLAREMONT, NH. 03743
_____, PharmD**

This collaborative practice agreement represents a legal agreement between the undersigned Valley Regional Healthcare primary care provider and _____, Pharm.D., allowing Dr. _____ to monitor and prescribe warfarin for patients in the Associates in Medicine Anticoagulation Clinic. This contract is a requirement of the NH Board of Pharmacy for situations in which pharmacy practitioners are providing Medication Therapy Management services to primary care providers and their patients. This contract must be renewed on a biannual basis with each PCP. In addition, each patient must sign a written consent form allowing the pharmacist to manage warfarin therapy. Written patient consent must be renewed on a biannual basis.

- Referral to the Anticoagulation Clinic is accomplished in ATHENA by setting up an appointment for the patient to attend the clinic.
- The goal INR is determined by the patient's diagnosis, per protocol, but may be overridden by the primary care provider when warranted. If the INR goal is in doubt, the pharmacist will contact the PCP for guidance, with documentation of same noted in ATHENA.
- Each patient new to warfarin will have a 60-minute training session with the pharmacist. They will be given written and verbal information to help them understand why they have been prescribed warfarin, and how to safely use this medication. Thereafter, follow-up appointments will generally be 20 minutes in length.
- Details of each clinic visit will be forwarded to the PCP in ATHENA for your review and sign-off. You are always free to override the decision made by the pharmacist. In such cases, it is your responsibility to notify the patient of the desired change in dosing or frequency of follow-up.
- A copy of the patient consent form/agreement has been provided for your review.

Signing this document expresses your understanding and you agree to the above guidelines and the consent form the patient has signed and agreed upon.

_____, PharmD

Provider Signature _____ Date _____

Provider Name Juliann Barrett, DO
Please Print

Provider Signature _____ Date _____

Provider Name Fernanda Miletto, MD
Please Print

Provider Signature _____ Date _____

Provider Name Marcella Meier, APRN
Please Print

Provider Signature _____ Date _____

Provider Name Katherine Cooper, APRN
Please Print

Provider Signature _____ Date _____

Provider Name Roy Barnes, MD
Please Print

Provider Signature _____ Date _____

Provider Name Bernard Rosen, MD
Please Print

Provider Signature _____ Date _____

Provider Name Alan Rogers, DO
Please Print