WPQC COMPREHENSIVE MEDICATION REVIEW AND ASSESSMENT DOCUMENTATION (LEVEL II)

Name: **Member ID Number:** **PCP:**
DOB: **Resides in nursing home (circle):** Yes/No **NPI:**

Appointment Type (circle): Initial Follow-up _____ type **Appt Date:** **RPh:**

Eligibility Criteria (circle): 2+cond/4+meds Diabetes Discharge w/in 14 days
Health Literacy Concerns Multiple Prescribers Referral by: _____

DAPO APPROVAL/BILLING
☐ Completed ☐ Not needed
PA#_____
Date of authorization _____
CPT Code: NEW 99605 EXISTING 99606

PRE-VISIT/DATA COLLECTION

☐ Appt scheduled
☐ HIPAA waiver signed (if needed)
☐ H&P given to patient
☐ ACT™ provided (asthma only)
☐ Request for patient labs/office notes
☐ Patient labs received
☐ Appt reminder completed
☐ H&P returned
☐ Pre-visit data documented
☐ Received signed consent for CMR/A

IMMUNIZATIONS

☐ Influenza
☐ Pneumococcal
☐ Hepatitis B
☐ Herpes Zoster
☐ TD/Tdap
☐ Other:

MEDICATIONS

CHRONIC CONDITIONS

☐ Asthma [49300]
☐ Heart Failure [4280]
☐ COPD [496]
☐ Chronic Kidney Disease [5859]
☐ CAD [41400]
☐ Osteoporosis [73300]
☐ Rheumatoid Arthritis [7140]
☐ Depression [311]
☐ Diabetes [25000]
☐ Dyslipidemia [2727]
☐ Hypertension [4019]
☐ Alzheimer's Disease [3310]
☐ Osteoarthritis [7150]
☐ End Stage Renal Disease [5856]
☐ Geriatric Syndrome (≥ 65 y/o)
☐
☐
☐

MED DEVICE INSTRUCTION

Reviewed proper use of:
☐ Glucose Monitor
☐ Injectables
☐ Inhalers
☐ Insulin
☐ Nebulizer
☐ Peak Flow Meter
☐ Blood Pressure Monitor
☐ Other:

ALLERGIES/INTOLERANCES

☐ NKDA
☐ Verified our records with patient
List allergies/intolerances:

POST VISIT

Consult Start time _____
End Time _____

☐ Embedded Level I's entered
☐ F/U Scheduled_____
☐ Patient Satisfaction Survey
☐ Sent MAP/PML in 14 days
☐ Fax sent/contact to HCP(s)
☐ Total time spent _____
☐ Pharmacy doc form complete
☐ Main DX Code _____
☐ Consult Session Duration _____
☐ Place of service_____
☐ Amt paid by other insurance
N/A or $_____
☐ Enter Fee & Verify Insurance
☐ Completed/Billed
☐ Reconciled
☐ Response from HCP received

HEALTH CARE UTILIZATION

In the past 12 months OR since last visit, number of times visited the:

ED____ Date: _____ Reason?

HOSP___ Admin Date: _____ Reason?

HCP Visits___ Date: _____ Reason?

ADHERENCE CONCERNS

How often do you have difficulty taking medications?
☐ Never, hardly ever
☐ Some of the time
☐ Most of the time
☐ All of the time
Notes:

CONSULT/DURING VISIT

Notes

Labs/Values C = confirmed UC = unconfirmed

BP_____ (C or UC)
Test Date:

HgA1c____ (C or UC)
Test Date:

LDL _____ (C or UC)
Test Date:

ACT™ Score_____
Test Date:

Other:

Clinical Reminders

- ☐ Patient goals
- ☐ Goals of therapy
- ☐ Adherence
- ☐ Device Instruction
- ☐ Vaccinations
- ☐ OTC/Herbal
- ☐ Lifestyle
- ☐ Follow-up visit

Assessment/Plan

Items to Follow-up on

Embedded Level I Recommendations

- ☐ Conversion to OTC
- ☐ Decrease Dose
- ☐ Dose Formulation Change
- ☐ Dose Consolidation
- ☐ Formulary Interchange
- ☐ Increase Dose
- ☐ Lengthen Duration
- ☐ Med Addition
- ☐ Med Deletion
- ☐ 90 day supply
- ☐ Shorten Duration
- ☐ Tablet Splitting
- ☐ Therapeutic Interchange

DIABETES FOCUSED CONDITION REVIEW

Medications

☐ ACE-I* ☐ Statin* ☐ ASA ☐ Glucagon
☐ ARB* ☐ Metformin ☐ Other_____

Labs/Values C = confirmed UC = unconfirmed

BP _____ (C or UC)
Test Date:

HgA1c ____ (C or UC)
Test Date:

LDL _____ (C or UC)
Test Date:

Other:

Notes

Clinical Reminders

☐ Hypoglycemia
☐ SMBG
☐ Med Addition: ACE-I/ARB, statin
☐ Adherence
☐ Device Instruction
☐ Vaccinations Influenza Pneumo, Hep B
☐ Eye Exam
☐ Foot Exam
☐ Lifestyle

Assessment/Plan

Items to Follow-up on

Embedded Level I Recommendations

☐ Conversion to OTC
☐ Decrease Dose
☐ Dose Formulation Change
☐ Dose Consolidation
☐ Formulary Interchange
☐ Increase Dose
☐ Lengthen Duration
☐ Med Addition
☐ Med Deletion
☐ 90 day supply
☐ Shorten Duration
☐ Tablet Splitting
☐ Therapeutic Interchange

ASTHMA FOCUSED CONDITION REVIEW

Medications

☐ Inhaled Corticosteroid (ICS)*
☐ Rescue Inhaler (SABA)
☐ LABA
☐ Other_____

Labs/Values

C = confirmed
UC = unconfirmed

ACT™ Score _____
Test Date:

Other:

Notes

Clinical Reminders

☐ Asthma Action Plan
☐ Adherence
☐ Device Instruction
☐ Educate Controller/Rescue
☐ Step up/down therapy
☐ Check for thrush
☐ Triggers
☐ Vaccinations Influenza Pneumococcal
☐ Lifestyle

Assessment/Plan

Items to Follow-up on

Embedded Level I Recommendations

☐ Conversion to OTC
☐ Decrease Dose
☐ Dose Formulation Change
☐ Dose Consolidation
☐ Formulary Interchange
☐ Increase Dose
☐ Lengthen Duration
☐ Med Addition
☐ Med Deletion
☐ 90 day supply
☐ Shorten Duration
☐ Tablet Splitting
☐ Therapeutic Interchange

HEART FAILURE FOCUSED CONDITION REVIEW

Medications

☐ ACE-I*
Dose Optimized? (circle)
Yes/No/Not Appropriate/Titrating

☐ ARB*
FDA Approved? Yes/No (candesartan, losartan, valsartan)
Dose Optimized? (circle) Yes/No/Not Appropriate/Titrating

Beta Blocker Use*
☐ Bisoprolol Dose Optimized? (circle) Yes/No/Not Appropriate/Titrating
☐ Carvedilol Dose Optimized? (circle) Yes/No/Not Appropriate/Titrating
☐ Metoprolol succinate Dose Optimized? (circle) Yes/No/Not Appropriate/Titrating
☐ Other beta blocker
☐ None

Labs/Values C = confirmed UC = unconfirmed

BP _____ (C or UC)
Test Date:

HR _____ (C or UC)
Test Date:

Other:

Notes

- Patient knows how to take his/her blood pressure? Yes/No
- How often does patient monitor his/her blood pressure?
  ☐ Never ☐ < 1/wk ☐ About once per wk ☐ > 1/wk ☐ Daily ☐ More than daily
- In the past 2 weeks, has the patient gained ≥ 3 lbs in one day or ≥ 5 lbs in one week? Yes/No

Clinical Reminders

☐ Daily weights
☐ Adherence
☐ SOB and/or DOE
☐ Edema
☐ Orthopena and/or PND
☐ OTC products to avoid
☐ Titrate to target dose
☐ Lifestyle/Salt intake
☐ Vaccinations Influenza Pneumococcal

Assessment/Plan

Items to Follow-up on

Embedded Level I Recommendations

☐ Conversion to OTC
☐ Decrease Dose
☐ Dose Formulation Change
☐ Dose Consolidation
☐ Formulary Interchange
☐ Increase Dose
☐ Lengthen Duration
☐ Med Addition
☐ Med Deletion
☐ 90 day supply
☐ Shorten Duration
☐ Tablet Splitting
☐ Therapeutic Interchange

DOE = dyspnea on exertion
PND = paroxysmal nocturnal dyspnea

GERIATRIC SYNDROME FOCUSED CONDITION REVIEW

Medication Issues

☐ Current number of PIMS (according to Beers Criteria 2012) _____

Risk Factors for Falls

☐ History of Falls

# of falls in past 12 months OR since last visit_____

Clinical Reminders

☐ Renal/Hepatic Function
☐ Prescribing cascades
☐ Anticholinergic Burden
☐ Address PIMS
☐ Drug-drug interactions
☐ Adherence
☐ Fracture Prevention
☐ Vaccinations
Influenza, Pneumococcal
Zostavax, Td/Tdap

Assessment/Plan

Items to Follow-up on

Labs/Values

C = confirmed
UC = unconfirmed

BP _____ (C or UC)
Test Date:

Other:

Embedded Level I Recommendations

☐ Conversion to OTC
☐ Decrease Dose
☐ Dose Formulation Change
☐ Dose Consolidation
☐ Formulary Interchange
☐ Increase Dose
☐ Lengthen Duration
☐ Med Addition
☐ Med Deletion
☐ 90 day supply
☐ Shorten Duration
☐ Tablet Splitting
☐ Therapeutic Interchange

WISCONSIN PHARMACY QUALITYCOLLABORATIVE
an initiative of the pharmacy society of wisconsin

Comprehensive Medication Review and Assessment Consent Form

Check the box indicating who is authorizing the CMR/A
□ Patient (Complete section I)
□ Caregiver (Complete section II)
□ Pharmacy staff representative on behalf of patient for telehealth visit (Complete section I)

I. I hereby authorize _____ Pharmacy to review my medications. I understand that any changes to my medications will not be made without the permission of my physician(s).

I understand that every effort will be made to maintain the confidential nature of my personal health information.

Signature of Patient: _____ Date: _____

Print Patient Name: _____

II. I _____ (caregiver name), hereby authorize _____ Pharmacy to review the medications of _____ (patient name). I understand that any changes to my medications will not be made without the permission of the physician(s).

I understand that every effort will be made to maintain the confidential nature of this personal health information.

Print Patient Name: _____

Signature of Caregiver: _____ Date: _____

Print Caregiver Name: _____