



Dentist/Pharmacist Relations: Professional Responsibility, Scope of Practice, and Rational Prescription Writing

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ABSTRACT Earlier this year, CDA engaged the California Pharmacists Association in discussion about the relationship between dentists and pharmacists and the most efficient ways to handle prescriptions. Professionals agree that the situation where a pharmacist fails to fill a dentist-written prescription does not occur frequently. However, when it does occur, all parties — the dentist, the pharmacist and the patient — are challenged. This discussion led to the following interview.

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INTERVIEWEES

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Let's begin with talking about the shared interest of both professions to ensure appropriate care for patients.

Q How do patients benefit from a shared responsibility in properly prescribing and dispensing drugs? Is there a system of checks and balances in play?

DR. LOFHOLM: In terms of benefits to patients, the health care system has always had a system of checks and balances. The prescriber, in this case the dentist, has the responsibility to make the diagnosis, establish the therapeutic goals, and select the appropriate therapy for that purpose. This may or may not generate a prescription. Health care providers don't always prescribe drugs; other kinds of therapy could be education or referral, surgery, or other such things.

Then the prescription is given to the pharmacist either directly from the dental office or from the patient, and the pharmacist's responsibility is to verify and validate the prescription given whatever clinical data is available. Is it the right patient? Is it the right drug? Is it the right dose?

The pharmacist has equal responsibility with the prescriber in terms of what the patient ultimately gets. The pharmacist is the last person on the health care team to make sure that the patient is getting what is intended.

Historically, pharmacists compounded prescriptions. In doing so, they prevented obvious overdoses because of decimal errors or therapeutic incompatibilities. We've taken that secondary role as oversight, if you will, and as the last checkpoint. Our job is to in-

terpret what the dentist prescribes, to validate the order to extent that we can, and to properly label, counsel, and advise the patient on how to use the medication.

DR. JACOBSEN: On the dentists' side of things, we do have the responsibility, as previously mentioned, to make the diagnosis and when necessary write the appropriate prescription. We depend greatly on the pharmacist — I like to think not to interpret the prescription because it should be clearly written — but certainly as counselor to the patient and dentist about safety, drug interactions, and things we may not be aware of because, as you know, dentistry and medicine, and pharmacy are getting incredibly complex these days. Dentists and physicians depend on pharmacists for their special knowledge not only in understanding and dispensing drugs, but also in advising the patient and the dentist relative to the safety, complications, or potential problems.

DR. LOFHOLM: In that regard, a pharmacist should have a complete drug history and balance off the new prescription against that drug history. Likewise, the dentist has a responsibility to do a drug history as well. Drug interactions are particularly important, and any questions about this are essential communication points for dentists and pharmacists.

Q What do dentists need to understand about the responsibilities, obligations, and laws governing the profession of pharmacy?

DR. LOFHOLM: Let's start very general. Health professionals are licensed to prescribe medications. If you consider a broad approach, they can prescribe anything, provided it is within their scope of practice, including training, to use the drug. I don't have a problem with dentists prescribing a drug as long as they understand what they are doing. The classic issue from an ethical point of view is a dentist who prescribes birth control pills for his dental assistant. Is that appropriate? I think you get where I am coming from.

Dentists usually write prescriptions to be filled only once. Acute pain and antibiotics are typically what's used. We're not used to seeing dentists write prescriptions for chronic disease. However, I do have a dental pain expert in my community, and I



Drs. Paul W. Lofholm (left) and Peter L. Jacobsen. (Photographs by Charr Crail)

would expect her to prescribe medication for chronic pain such as TMJ; but this not a typical situation. When I see a prescription from a dentist, it's usually a single fill for an acute episode. Once we enter the chronic therapy arena, we have a monitoring piece that we need to look at.

So, the pharmacist would generally ask the question: Is the patient being monitored or not? As long as there is an

understanding that there is an ongoing relationship, I personally don't have a problem with a dentist prescribing whatever. If there is a dentist prescribing a drug for an indication that is not in the package insert, the official FDA labeling, then it is incumbent upon the prescriber to be able to justify his or her actions. This does not mean that what they did was wrong, but if there is a question of liability, the burden of proof is upon the prescriber and secondarily upon the pharmacist. Why did the prescriber do this and why did the pharmacist dispense it? These are the questions that would be asked. But we have plenty of literature that says people do things "off label" and that could be a gray area.

Because I'm not used to filling prescriptions for dentists on a chronic basis, that might raise red flag. If a prescription comes to my desk, and I have a question, I would do one of two things. If I do not know the dentist, I would make a judgment that it should or should not be filled, given the equal responsibility question. Or, I could telephone the dentist and ask: 'What are you trying to accomplish with this prescription?'

What we need to establish is whether the prescription is safe and appropriate for the patient or not, hence the inquiry. That's really where we are coming from.

DR. JACOBSEN: I agree with what you describe. I understand there are two questions that come up regularly. One is about legibility, and of course prescriptions should be legible and accurate. I think dentists understand and appreciate any communication about this. The key thing is scope of practice. Even dentists have a difficult time keeping up with scope of practice in dentistry. As you defined, scope of practice not only involves what's taught in dental school, but also what is learned through experience, as well as additional training. I would think it is a challenge for a pharmacist to keep up on scope of practice for dentists as well as pharmacists and physicians.

How does a pharmacist define scope of practice?

DR. LOFHOLM: Generally, the law reflects on dentists working on the oral cavity, oral pathology, and diagnosis. Having said that, what is the relationship between the mouth and the rest of the body? As you know, there are plenty of issues to deal with, from systemic infection to heart disease. So, a pharmacist would not have a problem with mouth-related issues. Beyond that, they may challenge it. That's where we have to understand the groundwork.

If you want to treat pain, one question is: "Where is the pain?" If it's related to the mouth, that's not a problem. If it's related to the knee, that could be a problem. That's the kind of issue we're looking at. Say an ophthalmologist prescribes prednisone to a patient to treat iritis, and three weeks later the patient dies due to the systemic effects of the prednisone. So, those are the kinds of questions we at least ask about. Again, depending on the thoroughness and clinical experience of the prescriber, it may or may not be a problem.

To summarize, the scope of practice for dentists in a typical setting involves treating the oral cavity. It generally does not involve treating systemic diseases or conditions. It is typically a one-time prescription and hence not a chronic-use situation. If the medication does become chronic, a monitoring plan should be in place to assess the efficacy and toxicity and should be documented in the patient's chart. This falls with a more medical model and an ongoing chronic-treatment model.

DR. JACOBSEN: To further clarify the pharmacist's role in deciding scope of practice for dentists, as you explained, the pharmacist looks for education and experience to make that definition. That seems reasonable. If it feels like it's out of the scope of practice per the law, the pharmacist will call the dentist and it's incumbent upon the dentist to educate the pharmacist about specific training and background. This is something within the realm of dentistry, which has to do head and neck pain. So this is purely a communication and education issue for everybody.

DR. LOFHOLM: The main issue we need to get across is the communication side.

There may be things I may suggest therapeutically that you have not thought of before. There may be issues you're trying to treat that I have not considered before. As we get into the

specialties — it's one thing to talk about the tooth — but for example, what about dry mouth? Is it a systemic cause? It is a local cause? Is it secondary to radiation or secondary to other disease? Because we're close to University of the Pacific and UCSF dental school, we receive prescriptions that are atypical. But these specialists are trying to meet special therapeutic dental needs.

DR. JACOBSEN: I like what you are saying about communication and mutual growth and education as the appropriate way to ensure that things continue smoothly for the safety and benefit of the patient.



Drug interactions are particularly important, and any questions about this are essential communication points for dentists and pharmacists.

Q Can you discuss the scope and obligation of pharmacists in suspected drug diversion?

DR. LOFHOLM: Controlled substances are defined in the law because they have potential for abuse and misuse. The pharmacist's responsibility is to establish a legitimate medical or dental need for the use of these substances. It is illegal to treat an addict. We have some pretty elaborate patient activity. For instance, the patient who brings X-rays to a dentist and says, "See how bad my teeth are, I need Vicodin." The pharmacist has the responsibility to establish that there is a bona fide dentist-patient relationship. I have the

responsibility to verify it is a legitimate prescription, including asking for patient identification at the time of dispensing.

Just because a dentist writes a prescription does not mean that I will automatically fill it. Another way to look at the whole question is to ask: Is there any reason why I should not dispense this prescription? There are about 20 reasons why I wouldn't. Diversion is an issue that we are alert to and sensitive about.

There was a case in Fresno where a pharmacist was adjacent to an oral surgeon and the pharmacy's dispensing of controlled substances was high. Is that legitimate? Of course it is. There is not a problem with this situation as long as you understand it. On the other hand, there was a situation in San Francisco where a guy would pick up street people and take them to a physician 20 miles away in San Leandro who would write prescriptions for money. The prescriptions were filled in two pharmacies back in San Francisco. The individuals involved would be given money to buy the drugs, which they would turn over as soon as they walked out of the pharmacy. Then they would receive their payment, which typically was a bottle of wine. These drugs were

ending up in the streets of Seattle and Philadelphia with San Francisco pharmacy names on them. People who want to abuse drugs will go to extremes. Dentists might be hit by these same kinds of individuals. We have to be on guard, frankly.

DR. JACOBSEN: The responsibility of pharmacists has to be emphasized. This is an opportunity for dentists who don't want to be hit upon by these drug-seeking individuals. If something does not seem right, you need to call the pharmacist and say something doesn't seem to fit here. With specific patients, pharmacists can check their records for patterns of abuse.

DR. LOFHOLM: Typically if such a patient is going to work a pharmacist, he would come into the pharmacy with a questionable prescription at 5 p.m. on a Friday after the dentist has shut his door and gone home.

Q Can you please comment on the broadening scope of dental medicine and give some specific examples of drugs that are appropriate in dental medicine?

DR. JACOBSEN: As Dr. Lofholm said, the most common prescriptions dentists write are for classic antibiotics and pain medications, and they are for short-term use. There are other oral problems that dentists are now trained to treat in dental school as well as the problems they are learning to treat in continuing education and advanced training programs, including oral soft tissue diseases — lichen planus, pemphigoid, and other vesicular bullous diseases — which respond to corticosteroids. Those kinds of prescriptions are appropriate for a dentist to write, but since these are often chronic medications, pharmacists may feel they need additional documentation that these medications are being prescribed appropriately.

The other area where dentists are getting involved, and where training does occur, is in chronic head and neck pain. This is beyond a bad toothache and includes trigeminal neuralgia, atypical migraine, and a variety of head and neck pain a dentist didn't learn about in dental school. Advanced training programs in oral medicine, oral surgery, or periodontics include education about diagnosis and management of such problems. Medications used to treat these problems are things such as Neurontin and antidepressants. These clearly have never been in the scope of practice for dentists in the past, but now are appropriate, depending on the dentist's training.



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So, once again, communication is crucial. Once a pharmacist understands the purpose — that this is head and neck area pain — and that the dentist has made the appropriate diagnosis, conducted the appropriate tests, understands the appropriate pharmacologic management, and has in place a way to monitor the chronic use of these drugs, then that's communication and that's education. That's where proper prescribing for the benefit of the patient takes place.

DR. LOFHOLM: The way to facilitate this would be to include in the directions the purpose for the drug that you are treating pain, for example. That would clarify many issues. Antidepressants, for example, can be used for a variety of reasons including depression, but can also affect neuropathic pain.

We are moving in a direction to have the purpose of the medication as part of the directions for use. That would likely solve more than 50 percent of the problems encountered.

DR. JACOBSEN: That's simple and a great idea that dentists may not be aware of.

Regarding off label use, I prescribe Lidex ointment for oral lesions, so it is an intraoral use, but the package says for extraoral use only. I have to explain this to patients. This is a recognized off-label use. Is there a simple way to communicate this to the pharmacist?

DR. LOFHOLM: Putting the use in the directions would be fine. Are you using compounded products, such as Orabase compounded with Lidex?

DR. JACOBSEN: I've given up on requesting compounded medications.

DR. LOFHOLM: Compounded medications can be a secondary problem. Most pharmacies do not compound. I happen to, but most do not. So that's another issue.

If you wanted to get a compounded prescription filled, find a pharmacist who is willing and capable of doing that. As you hand the prescription to the patient, inform him as to where he can get it filled in your locale. That makes it easier for the patient. There are drugs that are sometimes in short supply, are not stocked, or the pharmacist does not have the technique to do what you need. Calling the pharmacist ahead of time to check on availability is helpful and can save everybody time.

But as for prescribing Lidex, if you put in the sig "Apply two times a day for oral lesion." That makes it clear what you have in mind.

DR. JACOBSEN: Usually that will raise a red flag since it's not FDA-approved for oral use.

DR. LOFHOLM: I understand. Here's what's going to happen beyond that. The pharmacist is required to consult with the patient either in writing or orally about how to use the medication. I'm not saying it's done all the time. If they are handed a sheet of paper that says Lidex for topical use — unless it is edited to say it is going to be used in the mouth — that's a problem. It will create doubt in the patient's mind and affect their willingness to use the prescription. The pharmacist can help overcome this problem.

Q What drugs truly fall outside of the scope of dentistry and should not be prescribed?

DR. JACOBSEN: As Dr. Lofholm pointed out earlier, birth control pills. Some dentists unfortunately think it is innocuous enough, since it's not a drug of abuse. So they will prescribe such things as birth control pills, or for that matter even medicine for sinusitis when there is no oral component or complaint. Once again, dentists think it is innocuous because it is not a controlled substance.

What dentists have to understand is that pharmacists have a legal obligation and an ethical obligation to fill only within the scope of training. Even though dentists may be trying to help whomever they are prescribing for — by decreasing medicine costs for example — it's not legal.

DR. LOFHOLM: What I would say is treatment of systemic disease that is not related to the oral cavity. Let's say diabetes. We would recommend that a diabetic patient see a periodontist often. The question is, what about managing the diabetes? It is unlikely to be done by a dentist. Of course with training dentists could — they are no different than other health professionals — they understand the disease process. My bias is, is the patient getting the care he or she needs? If I am satisfied that is happening, then I don't have a problem.

DR. JACOBSEN: Another situation where dentists can overstretch their training is when they are writing a prescription for a medication that is legally within their training but the medication is being used for another part of the body. For instance, a patient with a bad hip getting 100 Vicodin from his dentist even when a physician has already legitimately prescribed the medication because of ongoing pain. The dentist can just be trying to help by saving the patient money by not having to go back to the physician. It may be based on good intentions but it is inappropriate prescribing.



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Another example is fungal infections for mucosal surfaces other than the oral cavity. Again, it's inappropriate for dentists to prescribe, even though they can legally prescribe anti-fungal medications.

It is better to disappoint someone early on by not writing an inappropriate prescription rather than disappointing the state dental board later.

One other area where the scope of practice is being challenged is smoking cessation. This is in purview and training of dentists, and they are encouraged to prescribe medications such as Chantix and Zyban in appropriate situations. However, some pharmacists find it uncomfortable to fill these prescriptions. In several states this very situation has been taken all the way to the state medical board for a decision. In all situations when the physician and pharmacist have been adequately informed and educated, dentists have been allowed to write such prescriptions. It seems to be a matter of education.

Q What prescription drugs fall within what could be considered a gray area in relation to dental practice?

DR. JACOBSEN: As far as gray areas, for dentists who are trained in smoking cessation, Chantix is not a gray area. But for other dentists, it is considered a gray area; they don't feel comfortable prescribing it. For many pharmacists, it would be a gray area. I think this is a good current example.

Other instance that could be considered a gray area is prescribing Zolofl for the management of chronic pain or Neurontin for neurological pain. As mentioned before, these are drugs that can be used by dentists, with appropriate training, to treat chronic head and neck pain.

DR. LOFHOLM: The Chantix red flag now is suicidal behavior, which implies that you need to do some psychiatric evaluation before you prescribe the drug. Chantix affects dopamine. Patients who have high dopamine levels may be schizophrenic versus patients with low dopamine levels who have Parkinsonism. So, the issue is that if you prescribe the drug and the patient has a mental health condition, the disease could be exacerbated by using the drug. The problem is that 85 percent of schizophrenics smoke. So a dentist doing a history at the chair and trying to sort this out could say this is a good drug to use. But he has to evaluate the risk.

Whenever we prescribe drugs, we are looking at the benefit versus the risk.

Is it better to have people not smoke? Of course the answer is yes, but I think the problem is that the drugs we give for schizophrenia cause people to want to overcome their dopamine problem. They want to get back to the high they had before and this becomes a pharmacological dilemma. So, from that standpoint, pharmacists may be a little gun-shy to have a dentist prescribe Chantix. Frankly, the drug is not doing very well. It is an interesting concept. You can stop smoking completely if you have psychological weapons do so. Or we can give you substitution therapy using things such as patches or gum, or you can use this new agent. The new agent works 40 percent of the time. It has some efficacy but it also has some risk. Before prescribing or dispensing, we will look at the benefits versus the risks.

Q Please comment on the broadening scope of pharmacy and professional responsibilities.

DR. LOFHOLM: Pharmacists have expanded their scope. For instance, we give immunizations now and manage, under protocol, patients in hypertension or diabetes. Pharmacists can alter the dosage or strength in terms of appropriate use of medications. We can order lab tests in respect to monitoring drug therapy. We are also in the area of medication management. If you look at the RVS code or CPT code, psychiatry manages medications and pharmacists also fall into that same category. If a dentist prescribes Vicodin, it's my responsibility to refill when appropriate — not too early or not too late — for that drug, and in no case after six months. So that's a given and it's universal. The question is could I prescribe Vicodin? We now have midlevel practitioners who actually prescribe controlled substances. Peter Koo, a pharmacy professor and pain-management specialist at UCSF, started this. He manages all the postneurosurgical patients at the university. So pharmacists also get involved in that situation.

Is it likely that a protocol could be developed between a dentist and pharmacist? Possibly. I don't know that I have thought about this before. Take chlorhexidine, for example. Should every patient get chlorhexidine? Should you and I enter into an agreement that under certain circumstances these patients may have it? There is no reason why pharmacists and dentists could not develop a collaborative agreement.



If a dentist prescribes Vicodin, it's my responsibility to refill when appropriate — not too early or not too late — for that drug, and in no case after six months.

Pharmacists also, de facto, may prescribe prophylactic antibiotics because the dentist is not aware of what to do in a certain situation — if a patient can't take penicillin for example. Or, say, I'm across the hall from a cardiologist and I see a lot of patients with hardware and a patient comes to me and says I have to go to the dentist tomorrow and I'm supposed to take an antibiotic. Will you take care of it? I, in essence, prescribe it although I ultimately consult with the dentist or the cardiologist. So we're facilitating the appropriate use of drugs.

DR. JACOBSEN: There is the use of the term "expanding scope of practice." It could be better couched that all health care providers are looking to better serve the medical, dental, and pharmaceutical needs of patients in a knowledgeable, efficient, and economic way. I think we will see more of this blending to optimize the time and the skills and responsibilities of the different specialties of health care. The term "expanding scope of practice" sometimes has a threatening connotation. The intention is that everyone is looking for better ways to serve the health needs of the public.

DR. LOFHOLM: If we look at it from what we teach pharmacy students, which is: Given the diagnosis, what is the appropriate therapy? So patients understand it, understand the prognosis, and can select the appropriate therapy. This doesn't mean they do it, but ultimately in making this validation, they bless it or authorize it.

Q What things (indicators, situations) cause a pharmacist to not fill a prescription?

DR. LOFHOLM: The issue of not filling prescriptions comes down to whether the drug is appropriate for the patient or not. I might ask a patient: What did the dentist tell you about this prescription? Often what we see is a prescriber issuing a piece of paper to get filled. So the question is: Was there communication about this prescription? Now, this does not mean the dentist did not think about it but perhaps just didn't communicate it to the patient. What we are trying to figure out is what happened during this encounter.

If this prescription came from University of the Pacific dental center as opposed to my neighborhood dentist, there is an implied cutting edge. The question becomes: What about this? Is this something he heard at a seminar last weekend? And this is

OK. We then just need to verify what is known about this medication and if there has been consideration about specifics such as what other drugs the patient is taking.

So, if you are conservative you don't do anything. If you are liberal, you ask questions and, ideally, you ask appropriate questions to resolve the issue. That's where we are coming from.

DR. JACOBSEN: Communication is crucial between the pharmacist and the dentist, but it starts with dentists communicating effectively with their patients and making sure they understand why they are getting the medication. That is just good dental practice.

DR. LOFHOLM: A good reference is the chapter on "Rational Prescription Writing" that is in the *Basic and Clinical Pharmacology*, 10th edition. It goes through the thought process that a prescriber should use.

Q What guidelines do pharmacists use to make their decision to fill or not fill a prescription?

DR. LOFHOLM: Is there any reason why I should not fill this prescription? That is the basic question.

As a rule, a pharmacist will have a higher index of suspicion if a dentist prescribes any medication not associated with the oral cavity until they are satisfied that the prescriber has necessary knowledge. Again, because of the responsibility question: Why did you dispense the medication if you knew the dentist was treating a toenail infection and not an oral cavity infection?

To be fair, because dentists are not prescribing drugs as often as physicians, the pharmacist may spend more time looking at a prescription if it is out of the ordinary. I have no problem with an antibiotic or a narcotic, but once we go off into other areas, then the question is whether the patient is being served. As long as we establish that, it's not a problem.

Q Are pharmacists required to contact dentists if there is a question about the prescription?

DR. LOFHOLM: They are not required to contact dentists. They may look at prescription and say, "I can't fill it" or "I won't fill it."

Most of the time, if I know the patient and have no clue who the dentist is, I will call and say, "Tell me what you are you trying to accomplish here."

On the other hand, the number of prescriptions filled by pharmacists this decade will double. We're going from 3 billion to 6 billion prescriptions per year. So pharmacies are busy places.

Also, it's my experience that problems are not likely to be therapeutic. The problem is likely to be insurance coverage. When I submit online, my Drug Enforcement Administration number goes in and ultimately my National Prescribers Identification number. If I am not "on the list," the submission will get rejected. So, the issue may be if a prescription is presented to me, and I put in the dentist's number and it gets rejected, I'm not likely to call him or her and say the insurance company won't honor this. Now, I can manipulate the situation, depending upon how well I know the patient. I can ask who the primary physician is and have him or her be the prescriber and let the dentist know.

DR. JACOBSEN: As you said, prescriptions are going to double. There are times when dentists don't know about an NPI number. One area of not getting a response from a pharmacist could be a purely technical aspect of dentists not registering properly. Dentists need to keep up on this.

I would like to pin down a detail. Dentists have the perception that it's legally required for pharmacists get in touch with them if they do not fill a prescription. You're saying that is not so?

DR. LOFHOLM: It's an ethical question, but not a legal question. From a practical standpoint, I'm processing papers across my desk. Some will go through and some will not, for various reasons, one of which may be the problem with a particular drug. Remember, if I am a good businessperson, I will try to figure out who this guy is. And by the way, if you ever have a patient in Marin County, call me. So there may be other reasons to establish this relationship.

The questions that you raise in terms of gray areas, I don't think I've seen for a long time anything in the pharmacy literature about this. We talk about it in terms of physicians and podiatrists a little bit, but I don't think we've seen any literature in terms of dentists. It's an important area to look at. We may need to support your prescribing practices in a scientific way, if we can, especially concerning drugs that are not traditionally prescribed by dentists.

If you look at barriers to getting prescriptions filled, there are many. What we are trying to do is break down these barriers.



Communication is crucial between the pharmacist and the dentist, but it starts with dentists communicating effectively with their patients.

Q How can dentists professionally communicate with pharmacists about the drugs they can prescribe?

DR. LOFHOLM: We talked about putting in the sig, the directions for use, including the purpose. Some prescribers don't what to hang their hat on making a diagnosis and that's OK. At least if we get at the purpose, we can do that. We can go so far as to say "If there are any questions about this prescription, call me." This could be done, but we don't see this very often. If a prescription is unusual, that's what I would suggest.

If a case ends up in court, the pharmacist will be asked: 'Did you communicate with this person? Did you establish that this was legitimate?'

Q Are there any proactive measures dentists can take to help ensure that their prescriptions are filled?

DR. JACOBSEN: Make sure the sig is adequately descriptive.

DR. LOFHOLM: If you want to prescribe something that is generally not available, difficult to prepare, or unusual, then you might want to set up a network of pharmacies to handle those situations. It may be necessary to establish places where your prescriptions can be filled, in order to minimize the barriers for the patient.

If you are into exotics, a patient can spend a long time, including days, trying to find a drug. Ultimately, it would be good to try to facilitate getting your order carried out.

My objective is to analyze the order, and if it's appropriate, get it to the patient.

Q Is there anything about this issue you would like to add?

DR. JACOBSEN: Dentists and hygienists may have over-the-counter products they recommend to patients. In this situation, it's valuable to find a local pharmacy that is comfortable stocking the products and know that you'll refer patients there. This helps eliminate a barrier to patients getting what they need.

DR. LOFHOLM: We should at least touch upon that some dentists dispense medications. I think we should reference the rules of dispensing. An endodontist may put tetracycline in an envelope and give it to the patient. This is not appropriate packaging. It's not child proof or resistant to the environment, etc.

Questions Pharmacists Consider Before Dispensing a Medication:

- What are the benefits versus the risks of the medication?
- Is the prescription safe and appropriate for the patient?
- Is there any reason why I should not dispense this medication?
- Is the patient being monitored?
- What is the prescriber trying to accomplish with this prescription?'
- Was there communication with the patient about this prescription?
- Has there been consideration about other drugs the patient is taking?

Tips for Writing Prescriptions

- Make sure the signature is adequately descriptive. Include in the directions the purpose for the drug, especially if it is an "off-label" use.
- Communicate effectively with patients to ensure they understand why they are receiving the medication.
- If prescribing a medication that could be considered unusual, write a note to have the pharmacist call if there are any questions.
- If prescribing medications that are difficult to prepare or unusual, set up a network of pharmacies to handle those situations.

Requirements for Prescriber Dispensing

A dentist may dispense drugs to his or her patients at his or her place of practice if all of the following conditions are met:

- Drugs were not furnished to the dentist by a nurse or physician attendant
- Drugs are necessary for the dentist's treatment of the patient
- Dentist does not keep a pharmacy or other retail operation to furnish drugs
- Fulfills all labeling, recordkeeping, and packaging requirements, including the use of childproof containers
- Dentist does not use a dispensing device, unless the dentist personally owns the device and its contents
- Prior to dispensing, the dentist must offer to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy
- Dentist provides patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice
- Drugs dispensed by a dentist must be properly labeled with the prescriber's name, patient's name, drug name, date of issue, dosage, quantity, directions for use, expiration date, physical description of the drug, and, if requested by the patient, the condition for which the drug is dispensed. False or misleading information may not be included on a prescription label.
- Drugs to be dispensed must be stored in a secure area, which means a locked storage area within the dentist's office. The keys to the locked storage area shall be available only to staff authorized by the dentist.
- A record or log of drug acquisition and disposition must be maintained by the dentist. Records must be preserved for three years.
- A prescription is not necessary in the sale of controlled substances at retail in pharmacies or wholesale by pharmacies, wholesalers or manufacturers, to dentists and other licensed prescribers.
- A dentist with a current Drug Enforcement Agency registration may dispense to a patient under his or her care a Schedule II controlled substance in an amount not to exceed a 72-hour supply in accordance with normal use.
- For each Schedule II-, Schedule III-, or Schedule IV-controlled substance dispensed by a dentist, the dentist must record the patient's name, address, telephone number, gender, and date of birth; the prescriber's license category (dentist) and license number, DEA registration number, the National Drug Code number of the controlled substance dispensed; quantity of controlled substance dispensed; ICD-9 (diagnosis code) if available; number of refills ordered; whether drug was dispensed as a refill or as a first issue; and date of prescription. This information must be reported to the state Bureau of Narcotics Enforcement CURES Program. The reporting requirement does not apply to the administration of the controlled substance. It also does not apply to the dispensing of Schedule IV controlled substance in a quantity limited to an amount adequate to treat for 48 hours or less. Reporting the dispensing of Schedule II- and Schedule III-controlled substances must be done monthly unless a controlled substance is dispensed in a quantity to treat the patient for more the 48 hours, then dispensing must be reported weekly.

Samples

A dentist may furnish to a patient, at no charge, a limited quantity of drug samples if furnished in the package provided by the manufacturer. This transaction should be recorded in the patient record.

Resources

Bureau of Narcotics Enforcement CURES Program
 Business & Professions Code Sections 4076, 4077(b), 4078, 4170(a), 4171, 4172
 Health & Safety Code Sections 11158, 11190-11191, 11250-11251
 California Code of Regulations Title 16 Section 1356.3