

Title	Offender Medication Refill Request System			
Section	TX II-18	Issue Date December 23, 2020	Supersedes Date April 2012	Next Review Date December 2021

References

**Performance-Based Standards and
 Expected Practices for Adult Correctional
 Institutions, 5th Edition 5-ACI-6A-43 (M)
 Health and Wellness Policy and
 Procedure TX II-4, Medication
 Procurement and Returns**

I. PURPOSE

To provide a system that will develop autonomy and self-directed behavior among the offender population that requires offenders to be responsible for requesting medication refills.

II. POLICY

The Offender Medication Refill Request System guidelines establish a standardized system to ensure that all qualified offenders are educated to request medication refills. This will decrease staff time requirements and avoid medication waste, creating a more cost-effective system.

III. PROCEDURE

(a) Offender Qualification

(1) All offenders are automatic participants in the Self Administration Medication Program/Keep on Person (KOP) upon entry to DPS unless deemed incapable based on nursing assessment. Assessment includes physical and mental capacity.

(2) Qualification can be rescinded at any time.

(3) Refills for nonparticipating offenders shall be procured in accordance with the terms of the Health and Wellness Policy and Procedure Manual, Policy TX II-4, Medication Procurement and Returns.

(b) Education

(1) All qualified offenders shall receive education and training on the Offender Medication

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Refill Request System provided to the offender through facility communication.

(2) A patient education handout obtained in the EHR for the Self-Medication Program shall be provided to the offender, and its issuance recorded in the Patient Education section of the chart.

(c) Refill Request Initiation

(1) Offenders are responsible for requesting medication refills by completing an Offender Medication Refill Request (DC-875A). The forms will be made available to offenders through custody personnel.

(2) Offenders must submit the Offender Medication Refill Request (DC-875A) 10 days before the medication refill is due by placing the completed form in the sick call box.

(d) Request Processing

(1) Nursing

(A) Nursing staff shall be responsible for reviewing the Offender Medication Refill Request form (DC-875A) to determine refill eligibility and provide a response to the offender.

(B) Submitted Offender Medication Refill Request forms (DC-875A) must be processed by nursing staff within two routine operating days.

(C) Expired medication orders will be referred to the provider for review, when deemed appropriate.

(D) Offender Medication Refill Request forms (DC-875A) approved for a refill will be submitted to a DPS Pharmacy. Note: Central Pharmacy is for processing chronic disease and mental health medication refills using the Medication Refill Tracking System (MRTS); therefore, DC-875A forms do not need to be submitted to pharmacy for MRTS medications.

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(E) The facility will retain the original form (DC-875A) for 30 days.

(2) Pharmacy

The pharmacy staff will process the refill request when pharmacy records indicate the medication is due and a refill is remaining on the original order.

(e) Disposition

(1) Nursing will communicate confidential responses to the offender by returning a copy of the Offender Medication Refill Request (DC-875A) via inside mail. The form is to be folded and secured, with the offender name in view.

(2) Processed refills will be issued in accordance with the correctional facility's standard operating procedures.

(3) The Offender Medication Refill Request (DC-875A) is not to be filed in the offender health record.



_____ 12/23/20
 Todd E. Ishee Date
 Commissioner of Prisons



PRISONS
Health and Wellness Services
Policies and Procedures

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NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY - PRISONS OFFENDER MEDICATION REFILL REQUEST				
Offender Name:	Offender #:	Facility:	Dorm:	Date:
Medication # 1	Medication # 2	Medication # 3		
_____	_____	_____		
Medication	Medication	Medication		
_____	_____	_____		
Prescription #	Prescription #	Prescription #		
_____	_____	_____		
Refill until (date)	Refill until (date)	Refill until (date)		
_____	_____	_____		
OFFENDERS ARE NOT TO WRITE BELOW THIS LINE	OFFENDERS ARE NOT TO WRITE BELOW THIS LINE	OFFENDERS ARE NOT TO WRITE BELOW THIS LINE		
Nursing Staff Response	Nursing Staff Response	Nursing Staff Response		
<input type="checkbox"/> Current order expired, you will need to fill out a sick call form if you need this medication continued.	<input type="checkbox"/> Current order expired, you will need to fill out a sick call form if you need this medication continued.	<input type="checkbox"/> Current order expired, you will need to fill out a sick call form if you need this medication continued.		
<input type="checkbox"/> Your current order has expired; it will be referred to the clinician for review.	<input type="checkbox"/> Your current order has expired; it will be referred to the clinician for review.	<input type="checkbox"/> Your current order has expired; it will be referred to the clinician for review.		
<input type="checkbox"/> Your refill is not due. You need to submit another refill request form 10 days before _____ Date	<input type="checkbox"/> Your refill is not due. You need to submit another refill request form 10 days before _____ Date	<input type="checkbox"/> Your refill is not due. You need to submit another refill request form 10 days before _____ Date		
<input type="checkbox"/> Submitted to Pharmacy for refill.	<input type="checkbox"/> Submitted to Pharmacy for refill.	<input type="checkbox"/> Submitted to Pharmacy for refill.		
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
_____ Staff Signature/ Title Date	_____ Staff Signature/ Title Date	_____ Staff Signature/ Title Date		
MEDICAL/PHARMACY USE ONLY	MEDICAL/PHARMACY USE ONLY	MEDICAL/PHARMACY USE ONLY		
Additional Comments: _____	Additional Comments: _____	Additional Comments: _____		

This form may contain confidential medical information. It is the responsibility of the offender to protect his/her own medical information.
 This form is not to be amended, revised or altered without approval of the Medical Records committee.

FILE: Original – Kept in Medical
 Copy – To Offender
 DC-875A (Revised 11/20)