NEW YORK STATE
MEDICAID PROGRAM

Medicaid
Medication Therapy Management
(MTM) Provider Manual

Pilot Program
2009 - 2010

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NEW YORK STATE MEDICAID MTM PROGRAM

BACKGROUND

The 2008-2009 Executive Budget authorized implementation of a pilot medication therapy (MTM) service to improve therapeutic outcomes by optimizing responses to medication, managing treatment-related interactions or complications, and improving adherence to drug therapy.

Medicaid enrollees eligible to receive program services are identified through a review of medication and facility (emergency department and in-patient) Medicaid claims. MTM services will be provided by qualified Medicaid MTM pharmacists who possess a New York State license to practice pharmacy. MTM services will be billed by MTM designated Medicaid enrolled pharmacies who employ a qualified Medicaid MTM pharmacist.

The services provided to enrollees by qualified Medicaid MTM pharmacists include:

- patient assessment (medical history as related by the patient)
- comprehensive patient medication therapy review
- personal medication record (to be retained by the patient)
- medication action plan (for the patient to follow)
- assistance in finding a primary care physician (if needed)
- document problems, resolutions, education and evaluation of patient response to medication therapy including adverse events; and,
- follow-up to ensure patient adherence with medication action plan and to encourage patient self-management

Medicaid enrollees eligible to receive MTM services will be allowed one new patient visit and up to six established patient visits a year. MTM services will be provided face-to-face in a private consultation area within a community pharmacy. Qualified Medicaid MTM pharmacists will be required to establish and maintain a working relationship with the enrollee's primary health care providers (PCP) including linking the enrollee to a PCP when necessary.

The MTM program has begun as a pilot in the Bronx, initially limited to adult patients with an asthma diagnosis.

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PARAMETERS AND DESIGN

- Pharmacists and pharmacies meeting pre-specified requirements will be invited to enroll in the MTM pilot program.
- Enrollees will be able to select their MTM pharmacist and pharmacy. A list of qualified Medicaid MTM pharmacies will be provided in the enrollee invitation letter.
- During the initial MTM appointment, the pharmacist will conduct an enrollee medical history interview and perform a drug regimen review in order to identify medication issues. During the drug regimen review, the MTM pharmacist will address enrollee understanding of medications and how they help manage their disease, adherence difficulties, inhaler techniques, adverse drug reactions, drug interactions, identification of any inappropriate drug therapy, as well as any enrollee medication concerns.
- Following the initial visit, a letter describing the program as well as a report summarizing the MTM visit will be sent to the enrollee's primary medical provider. Per the professional judgment of the MTM pharmacist, copies of the report may be sent to other medical providers who have prescribed medications to the enrollee.
- For enrollees without a primary medical provider, the MTM pharmacist will help the enrollee find a primary medical provider and establish an enrollee-provider relationship.
- After the initial visit, the enrollee is eligible for up to six additional appointments, or up to a total of 285 minutes (total minutes includes initial visit), with their MTM pharmacist to discuss their medications. Payment for services is contingent on continued NYS Medicaid Eligibility.
- At each visit, the MTM pharmacist will provide the enrollee with appropriate written materials, personalized medication list and medication tips.
- Following every MTM visit, the pharmacist will document each encounter and provide the primary medical provider with a complete and up-to-date medication list, a summary report of the visit, and recommendations for potential changes to the current drug regimen, when appropriate. Communication between the pharmacist and primary medical provider should be open, collaborative and continue throughout the program.

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ELIGIBILITY AND PRACTICE REQUIREMENTS

PHARMACY

Pharmacies applying for a NYS Medicaid Medication Therapy Management designation must:

- Be enrolled and in good standing as a NYS Medicaid provider with a 0441 category of service code;
- Be licensed and registered in good standing with the New York State Board of Pharmacy;
- Be located in the Bronx (for the pilot program);
- Provide a dedicated space for private counseling that includes a table and chairs where the Medicaid enrollee and the qualified MTM pharmacist will not be distracted;
- Identify qualified Medicaid MTM pharmacist(s) on the pharmacy's Medicaid MTM designation request form. Medicaid will coordinate the training and enrollment of the pharmacist designated to provide Medicaid MTM services at the location indicated on the pharmacy application; and

In addition to the above requirements, all pharmacies participating in the NYS Medicaid MTM Program must employ or contract with a qualified Medicaid MTM pharmacist to receive payment. Pharmacies who meet all Medicaid MTM qualifications will be listed on the Department of Health MTM website.

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ELIGIBILITY AND PRACTICE REQUIREMENTS

PHARMACIST

Pharmacists must meet the following criteria to qualify as a Medicaid MTM pharmacist:

1. Be licensed and registered in good standing with the New York State Board of Pharmacy;
2. Be in good standing with the NYS Medicaid program; and
3. Participate in and successfully complete the required, Medicaid MTM training. This training program is ACPE accredited (Accreditation Council of Pharmacy Education).

If the number of pharmacists interested and eligible to provide MTM services exceeds the capacity of the pilot program, Medicaid may limit the number of participating pharmacists based on geographic location to assure that services are equally available from pharmacists throughout the Bronx.

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POLICY AND PROCEDURES

Medicaid MTM pharmacists and pharmacies are required to follow all established NYS Medicaid guidelines, rules and policies as outlined in the Medicaid Pharmacy Manual as well as the MTM specific Policy and Procedures provided in this manual and are responsible for all program updates provided by email, through the Medicaid Update, or on the Department of Health web site at: http://nyhealth.gov/health_care/medicaid/program/mtm/index.htm.

PHARMACY EXPECTATIONS

1. MTM visit will be conducted in a Medicaid MTM-designated retail pharmacy located in the Bronx for this pilot.

2. A Medicaid MTM-designated pharmacy must employ or contract with a MTM Medicaid Pharmacist to provide MTM services to Medicaid enrollees.

3. MTM services must be conducted in a private area, free of distraction, with a table and chairs.

4. Payment will be made to the Medicaid MTM-designated pharmacy.

5. The Medicaid MTM-designated pharmacy will bill through eMedNY, the NYS Medicaid electronic claims processing system, using the MTM designated CPT codes.

6. Medicaid MTM-designated retail pharmacies cannot provide incentives or discounts to participants in the Medicaid program.

7. Medicaid enrollees cannot receive MTM services from more than one Medicaid MTM-designated pharmacy at one time.

8. Each Medicaid MTM-designated pharmacy must retain a hard copy of the MTM Consultation Form, signed enrollee Consent for Release of Medicaid Information to Health Care Providers form and other documentation pertinent to the visit for a minimum of six years.

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CONDUCTING AN MTM ENCOUNTER

PHARMACIST EXPECTATIONS

1. **Before** the MTM Visit:

   Pre-visit Pharmacist Checklist – Appendix 1

   a. The Medicaid MTM pharmacist will meet all Medicaid requirements including successful completion of the NYS Medicaid sponsored MTM training prior to providing MTM services to Medicaid enrollees.
      i. Pharmacy technicians, pharmacy students or other non-pharmacist staff **are not** allowed to provide MTM services.

   b. The Medicaid MTM pharmacist will set up an appointment to meet with the Medicaid enrollee in a private area of the retail pharmacy.
      i. Suggested script for contacting the enrollee for an appointment:
      "Hello, Mr. /Ms _____________I am <your name>, the Medicaid MTM pharmacist at <pharmacy name>. I was notified that you chose to participate in Medicaid's medication therapy management program and would like to set up an appointment. When would you like to schedule your appointment to review your medications?
      I look forward to meeting with you. Please remember to bring all the medications and supplements you take with you for your visit and please bring your Medicaid card or your welcome letter and a photo id to our first visit."

   If you are unable to reach the enrollee to make an appointment, the suggested message is:

   "Hello, this message is for Mr. /Ms __________. I am <your name>, the Medicaid MTM pharmacist at <pharmacy name>. Please call me back at <phone number> so that we can schedule an appointment to review your medications.

   c. The Medicaid MTM pharmacist should be fully prepared to conduct the MTM visit at the time of the enrollee's appointment. The time required to prepare for this visit is not billable. It is required that the MTM pharmacist:
      i. Print the Consent for Release of Medicaid Information to Health Care Providers form – Appendix 2, to be signed at the first MTM visit.
      ii. Complete a review of the enrollee's medication history, if available.
      iii. Identify potential drug therapy problems, including missing medications or adherence problems from medication history, if available.
      iv. Print anticipated enrollee education handouts that may be needed for review with the enrollee.

v. Become familiar with the enrollee's chronic condition(s) and currently acceptable medication therapy for that condition(s).
vi. Print a blank NYS Medicaid MTM Consultation Form – Appendix 3.
vii. Place a reminder call to the enrollee 2 days prior to the MTM visit.

d. Verify the enrollee's Medicaid eligibility before each visit by using the Medicaid Electronic Verification System (MEVS). For more information on verifying eligibility, please go to:

   http://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf.

   Find Supplemental Documentation and select *"MEVS" Provider Manua*l. This manual provides options and steps to verify eligibility:

   http://www.emedny.org/ProviderManuals/index.html.

If a patient is no longer eligible, the MTM Pharmacist should contact the patient and inform him/her of the change in eligibility status. Patients should be directed to contact their local Department of Social Service with any questions regarding their eligibility.

2. **During** the MTM Visit:

Use the NEW YORK STATE MEDICAID MTM CONSULTATION FORM – APPENDIX 3 as a guide to the MTM visit and as a worksheet to document information gathered during the visit.

a. The Medicaid MTM pharmacist must provide the MTM services at a Medicaid MTM-designated pharmacy in the Bronx for this pilot.

b. The MTM pharmacist will check the enrollee's ID (photo Identification, Medicaid card, or participation invitation letter) to confirm their identity and eligibility for the program.

c. At the first visit the enrollee must sign the Consent for Release of Medicaid Information to Health Care Providers – Appendix 2. The MTM pharmacist is **not authorized** to continue the MTM visit with the enrollee until the consent form has been signed. The initial visit and any subsequent claims will not be reimbursed without this signed form.

d. The MTM pharmacist must keep the original signed consent form and send a copy of the signed consent form via fax to:

   SUNY at Buffalo
   School of Pharmacy & Pharmaceutical Sciences
   Attn: NYS Medicaid MTM Forms
   1-877-779-5654

e. The MTM Medicaid pharmacist will:

   i. Document patient assessment (medical history provided by patient) using the NYS Medicaid MTM Consultation Form – Appendix 3;
   ii. Conduct a comprehensive patient medication therapy review which should document the patient's use of all medications, including OTCs, herbals, and supplements as relayed by the patient;
   iii. Prepare a Patient MTM Summary Report – Appendix 5 for the patient;
   iv. Coordinate and assist with linking the patient to other health care resources (e.g., asthma coalitions) and provide pertinent materials to the patient to assist in managing their condition;
   v. Document drug therapy problems, recommended solutions, education and evaluation of patient response to therapy (MTM Consultation Form – Appendix 3 and Prescriber MTM Summary Report – Appendix 6);
   vi. Schedule follow-up appointments, as needed, to ensure patient adherence to their medication plan in order to determine that patient goals have been met;
   vii. Establish and maintain a working relationship with the patient's Primary Care Provider (PCP);
   viii. Link patients to a PCP if one is needed. Please refer to "When an Enrollee Needs a Primary Care Provider" in this manual;

ix. Provide the patient with a copy of their Patient MTM Summary Report – Appendix 5 and any applicable information to assist with the patient's medication regimen at the end of the visit if possible, or by mail within 2 business days of the visit.

f. MTM Medicaid pharmacists are **not** allowed to prescribe medications or change current drug therapies.

g. There are no enrollee copayments for Medicaid MTM services.

3. **Following** the MTM visit:

Post-Visit Pharmacist Checklist – Appendix 4

a. The MTM pharmacist will enter all documentation from the visit onto the forms. The time required to document this visit is not billable.

b. The MTM pharmacist will provide a Patient MTM Summary Report – Appendix 5 to the patient following every visit. This is to be provided immediately following each visit or mailed to the patient within 2 business days of the visit.
   i. If the patient has complicated medication regimen, or has difficulty adhering to their medications, the pharmacist can provide the patient with a personalized Patient Medication Schedule – Appendix 11.

c. The MTM pharmacist will establish and maintain a working relationship with the enrollee's health care providers, including sending written summaries and recommendations of all MTM encounters to all relevant prescribers (both primary care and specialists) using the Prescriber MTM Summary Report – Appendix 6. Providers must be contacted by phone for all interventions that require immediate attention. All written and verbal contacts must be documented in the patient's MTM record. The pharmacist must send a copy, via mail or secure fax, of the completed Prescriber MTM Summary Report – Appendix 6 to the appropriate medical provider(s) within 2 business days of the visit and include the appropriate cover sheet – Appendix 7 or 8 (Initial Prescriber Communication Cover Letter or Subsequent Prescriber Communication Cover Letter).
   I. Appendix 7 – Initial Prescriber Communication should be sent to a prescriber if that letter and report is the first one the MTM Pharmacist is sending about that patient.
   II. Appendix 8 – Subsequent Prescriber Communication should be sent to a prescriber for follow-up communication with a prescriber who has previously received MTM communication regarding the patient.

IMPORTANT: Medication recommendations by the MTM Pharmacist should be based upon evidence-based guidelines. Prior to making a medication recommendation, the MTM Pharmacist should be comfortable with disease and

medications included in the recommendation and should refer to available evidence and guidelines.

Additional references and a list of patient education resources can be found in Appendix 10.

4. **General Information**:

   a. Medicaid MTM pharmacists are required to follow all established NYS Medicaid guidelines, rules and policies.

   b. Medicaid MTM pharmacists may work for more than one Medicaid MTM-designated pharmacy. MTM pharmacists must notify the Department of Health, Bureau of Fee for Service Provider Enrollment department of any changes in enrollment information within 15 days of the change. Changes must be reported by completing the Change of Pharmacy of Pharmacist Request form – Appendix 9.

   c. Reimbursement for MTM services will only cover face-to-face, one-on-one contact with the Medicaid enrollee.

      i. Group visits **are not** allowed.
      ii. Time required for preparation of the MTM visit is not reimbursable.
      iii. Time required for follow-up/reminder telephone calls is not reimbursable.
      iv. Pharmacy cannot submit a claim for no show appointments.

   d. Medicaid enrollees cannot receive MTM services from more than one Medicaid MTM pharmacist at a time. Should the enrollee choose to obtain their MTM services from a different MTM Medicaid pharmacist or Medicaid MTM-designated pharmacy, the enrollee should contact the MTM program staff for assistance finding a new provider and facilitating the change.

ENROLLEE EXPECTATIONS

1. The NYS Medicaid MTM Program will select and invite eligible Medicaid enrollees to participate in this pilot.

2. Enrollee must sign a Consent for Release of Medicaid Information to Health Care Providers Form – Appendix 2 to authorize the release of identifiable personal health information to practitioners participating in the enrollee's care (e.g. physicians, nurse practitioners, etc.) who provide the enrollee with health care services and to pharmacists participating in the MTM program that provide MTM services.

3. Medicaid enrollees are expected to attend scheduled appointments.

4. Medicaid enrollees cannot receive MTM services from more than one Medicaid MTM pharmacist at a time.

5. There are no enrollee copayments for Medicaid MTM services.

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SECURITY AND RECORD RETENTION

All MTM encounter documentation (MTM Consultation Form, copies of Prescriber and Patient MTM Summary Reports) must be retained by the pharmacy for six years. The pharmacy must retain the original signed Consent for Release of Medicaid Information to Health Care Providers – Appendix 2. The method of retention should comply with all federal and state HIPAA requirements. It is the pharmacy's responsibility to retain these documents as documentation of the service delivered and should be readily available for audit requirements.

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WHEN AN ENROLLEE NEEDS A PRIMARY CARE PROVIDER

If the enrollee needs a Primary Care Provider, please refer them to:

Diane Strom, Administrator
South Bronx Asthma Partnership (SOBRAP)
Telephone: 718-960-1020
Email: dstrom@bronxleb.org

You may contact SOBRAP directly on behalf of the patient but no patient information may be communicated, as all HIPAA policies must be adhered to.

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MISSED APPOINTMENTS

If the patient does not attend a scheduled appointment, this must be documented on the Missed Appointment Form – Appendix 12. The MTM pharmacist is expected to make three calls to the patient within 5 days of the missed appointment in order to reschedule the appointment. Each attempt to contact the patient must be documented and should include the time and date of the call and phone number called.

After three attempts to contact the patient have been made without success, no further contact attempts are necessary. If the patient contacts the pharmacist or pharmacy after some time and wants to resume MTM appointments, then the patient may resume visits with that MTM pharmacist.

Please document missed appointments on the Missed Appointment Form – Appendix 12, and fax the form to the New York State Medicaid MTM Program:

SUNY at Buffalo
School of Pharmacy & Pharmaceutical Sciences
Attn: NYS Medicaid MTM Forms
1-877-779-5654

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BILLING PROCEDURES AND REIMBURSEMENT

Medicaid MTM pharmacies are eligible for reimbursement for the time an MTM pharmacist spends during a one-on-one, face to face visit with a patient enrolled in the MTM program. Payment for MTM services are made to NYS Medicaid MTM-designated pharmacies.

CPT Codes and Fees
Participating pharmacies should submit the following CPT codes electronically to receive reimbursement. Procedure code 99605 is allowed once per enrollee. The codes and fees are as follows:

CPT Code & Description	Fee	Frequency	Max/Yr/Enrollee
99605 – New MTM patient, 15 min	$35.00	Once	$35.00
99606 – Established MTM patient, 15 min.	$25.00	Max 6 claims in 12 months	$150.00
99607* – Additional 15 minutes	$15.00	Max 12 claims in 12 months	$180.00

** 99607 must be billed in connection with either 99605 (new patient) or 99606 (established patient) codes.*
**Maximum of three (3) uses of CPT code 99607 per patient per visit (total billable time with each patient cannot exceed 60 minutes per visit).*

Billing Requirements

MTM Pharmacists must bill in the HIPAA-compliant National Council for Prescription Drugs Program (NCPDP) 5.1 electronic format.

- The number of units is equivalent to the number of 15 minute increments (e.g., 1 unit = 15 minutes). The pharmacist must bill in 15 minute increments (the pharmacist may round the time to the nearest 15 minute amount, i.e., round down if 1-7 minutes and round up if 8-14 minutes). Note the frequency limitations. Also note 99607 billing codes must be used in conjunction with 99605 or 99606.

- The **NPI of the pharmacist** that performed the service should be reported in the Provider ID field (field 444-E9). The Provider ID Qualifier is reported in field 465- EY. The NPI qualifier is 05.

- The billing provider is the pharmacy. (Field 201-B1 for the **Pharmacy NPI**, field 202-B2 for the qualifier). Qualifier is 05.

- The **CPT/HCPCS** procedure code is submitted in the same manner as a supply item that is billed using a procedure code – the 5 digit procedure code (the CPT code). There is only 1field that can be used on the NCPDP format to enter the service being billed for – whether a drug, supply or service.
  The CPT/HCPCS procedure code is reported in field 407-D7 (Product/Service ID).

- **A value of "09"- (CPT/HCPCS) is reported in field 436-EI (Product/Service ID Qualifier field). Refer to the ProDUR/ECCA Standards manual on the eMedNY website for further details**

- Days supply- enter 1

- Prescription Serial number- enter 99999999

- Drug Refill Code- enter 0

- Drug Refills Count (Authorized) - enter 0

- Date of Service - enter the Claim Service Date (date service provided)

Examples:

Note: Two claims must be submitted if the visit exceeds 15 minutes.

1. MK's first MTM visit with the MTM pharmacist lasts 45 minutes. The MTM pharmacist should bill the following codes and service units:

   Claim #1: 99605 in the NDC field and 1 in the unit field.
   Claim #2: 99607 in the NDC field and 2 in the unit field.

2. MK's follow-up visit 3 weeks later lasts 25 minutes; the MTM pharmacist should bill the following codes and service units:

   Claim #1: 99606 in the NDC field and 1 in the unit field.
   Claim #2: 99607 in the NDC field and 1 in the unit field.

Additional Information

For additional information on billing procedures, please refer to www.emedny.org/ Under Provider Manuals - Pharmacy - Billing Guidelines and the ProDUR/ECCA Standards Manual.

You may also contact CSC at 800-343-9000.

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TRANSPORTATION

New York Medicaid assures transportation to Medicaid enrollees to and from Medicaid-covered services. The New York City Medicaid Transportation Program is administered by the City of New York Human Resources Administration, which encompasses the five boroughs of the City of New York, with oversight by the New York State Department of Health.

MTM services are covered by Medicaid; therefore transportation to and from the MTM visit is covered.

All transportation must be prior authorized for payment, and only select healthcare providers are enrolled and able to request transportation services. At this time, pharmacists are not able to request a prior authorization for transportation. However, if a Medicaid enrollee requires transportation assistance in order to receive MTM services, the MTM pharmacists should communicate this need to the enrollee's primary prescriber and assist and encourage the prescriber to request transportation for that enrollee.

For questions, comments and more information regarding transportation, please contact the MedicaidProgram'sTransportationUnit:

Telephone: (518) 408-4825
Fax: (518) 486-2495
Email: MedTrans@health.state.ny.us.

If a patient requires transportation, the MTM pharmacist should document this in the notes section of MTM Consultation Form – Appendix 3. If when scheduling the initial MTM visit with the patient, the MTM Pharmacist learns that transportation is needed, the pharmacist must ask the patient to provide the name and telephone number of a prescriber who is familiar with the patient and the pharmacist will contact this prescriber to request prior authorization for transportation.

The MTM pharmacists should document which prescriber was contacted to complete the transportation request in the Pharmacist Notes section of the MTM consultation form.

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DEFINITIONS / ACRONYMS

- **0441 COS:** Category of Service that retail community pharmacies must be enrolled in to bill and receive payments for drugs in the Medicaid outpatient pharmacy program.
- **ACPE:** Accreditation Council for Pharmacy Education.
- **Comprehensive Patient Medication Therapy Review:** Systematic review and evaluation of a patient's medication regimen, encompassing prescription and OTC agents. Includes any actions/recommendations needed to optimize treatment.
- **CPT Billing Increments:** For the MTM program, 1 unit (1 billing increment) will equal 15 minutes of time spent with a patient for MTM services.
- **CPT:** Current Procedural Terminology.
- **eMedNY:** New York State Medicaid claims processing services.
- **HIPAA:** Health Information Portability and Accountability Act.
- **Medicaid MTM Designated Pharmacy:** Pharmacy designated by Medicaid that meets all Medicaid MTM requirements and employees or contracts with a Medicaid MTM Pharmacists.
- **Medicaid MTM Pharmacist:** Pharmacist designated by Medicaid who is able to conduct and submit claims for MTM services and is employed by a Medicaid MTM Pharmacy.
- **MTM:** Medication Therapy Management.
- **NCPDP:** National Council for Prescription Drug Programs.
- **PCP:** Primary Care Provider.

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QUESTIONS AND ANSWERS

1. Can I provide the enrollee with additional educational information?
   Yes. If you feel that the enrollee would benefit from additional educational information, you may select a reference from the list of references provided in this manual – Appendix 10, or one that you select using your professional judgment.

2. Is there a diary or calendar tool that I can use to help enrollees adhere to a complicated medication regimen?
   Yes. See the Patient Medication Schedule – Appendix 11. You may complete this table and provide it to an enrollee who has a complicated regimen and needs help remembering when to take medications.

3. Can I provide an incentive to an enrollee to come to the first and/or follow-up MTM visits?
   No, incentives cannot be used for this program.

4. Can I bill for my time if the enrollee did not show up for their scheduled appointment?
   No, only time spent with an enrollee can be billed. If an enrollee fails to show, then the time is not payable.

5. Can I bill for counseling two enrollees at one time?
   No, MTM sessions should be for one enrollee per session. If a caregiver or provider attends the visit, the session can only be billed for the enrolled member.

6. Can I provide group counseling?
   No, group counseling is not part of MTM. MTM services should be provided one-on-one, face-to-face with an enrollee and a Medicaid MTM pharmacist.

7. Can I conduct an MTM visit over the telephone?
   No, MTM visits must occur face-to-face, in person, at a Medicaid designated MTM retail pharmacy.

8. Can I bill for my preparation time to get ready for the MTM visit?
   No, preparation time should not be billed (only time spent directly with the enrollee can be billed).

9. Can transportation be provided to enrollees?
   Yes. For more details, please see the section of this manual pertaining to transportation.

10. Can a patient's caregiver attend the MTM visit with the patient?
    Yes, with patient's permission.

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CONTACT INFORMATION AND OTHER RESOURCES

Medicaid MTM Program:

- Email: nymtm@nysdoh.suny.edu
- Call: 1-877-779-5653
  Voicemail is monitored Monday – Friday between 8:30AM – 5:00PM.
  Messages left outside of these hours will be returned by the next regular business day.
- Fax: 1-877-779-5654
- Mail: SUNY at Buffalo
  School of Pharmacy & Pharmaceutical Sciences
  Attn: NYS Medicaid MTM Forms
  Hochstetter 311
  Buffalo, NY 14260
- Web: http://nyhealth.gov/health_care/medicaid/program/pharmacy.htm

Medicaid Pharmacy Policy Inquiries:

- Email: PPNO@HEALTH.STATE.NY.US

Provider Enrollment Inquiries:

- Email: nymtm@nysdoh.suny.edu
- Call: 1-877-779-5653

Billing Inquiries:

- Call CSC (Computer Sciences Corporation) 1-800-343-9000

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APPENDIX 1

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PRE-VISIT PHARMACIST PREPARATION

APPENDIX 1

MEDICAID MTM PILOT PROGRAM

PRE-VISIT PHARMACIST PREPARATION

1. Review patient's medication history, if available. Check for the "flags" which could indicate lack of disease control, examples include:
   a. Early or frequent requests for, or fills of, short-acting asthma medications, such as albuterol inhaler or nebulizer, Xopenex inhaler or nebulizer.
   b. Inconsistent fills of maintenance medications. For example, a 30 day supply of an oral antidiabetic is filled every 45 days.
   c. No ACEI in a patient with diabetes who does not have any contraindications and is not currently taking an ARB.

2. Review patient's profile for previously documented allergies.
   Note: Allergy information is provided by the patient and documented at the first visit, so in preparation for the initial visit, allergy information will not be available.

3. Review patient's medication profile for medications that could indicate mismanaged triggers:
   a. Frequent fills or OTC purchases of antacids, H-2 blockers, PPI.
   b. Frequent fill of allergy medication, either OTC or prescription.

4. Review patient's medication profile for **potential** drug interactions:
   a. Non-selective beta-blockers in a patient with asthma
   b. Phenytoin and bupropion
   c. Verapamil and simvastatin

5. If possible, have applicable medication devices available for demonstration of administration technique.

6. Print blank MTM Consultation Form– Appendix 3 to document the MTM visit.

7. Print applicable and anticipated patient education materials.

8. Print Consent for Release of Medicaid Information to Health Care Providers – Appendix 2 (first visit only).

9. Verify and document the enrollee's Medicaid eligibility by using the Medicaid Electronic Verification System (MEVS) prior to each appointment.

   IMPORTANT: Medication recommendations by the MTM Pharmacist should be based upon evidence-based guidelines. Prior to making a medication recommendation the MTM Pharmacist should be comfortable with disease and medications included in the recommendation and should refer to available evidence and guidelines.

PRE-VISIT PHARMACIST CHECKLIST

- ☐ Review patient's medication history, if available.

- ☐ Review patient's profile for previously documented allergies.
  Note: Allergy information is provided by the patient and documented at the first visit, so in preparation for the initial visit, allergy information will not be available.

- ☐ Review patient's medication profile for medications that could indicate mismanaged triggers.

- ☐ Review patient's medication profile for **potential** drug interactions.

- ☐ If possible, have applicable medication devices available for demonstration of administration technique.

- ☐ Print blank MTM Consultation Form– Appendix 3 to document the MTM visit.

- ☐ Print applicable and anticipated patient education materials.

- ☐ Print Consent for Release of Medicaid Information to Health Care Providers form – Appendix 2 (first visit only).

- ☐ Verify and document the enrollee's Medicaid eligibility by using the Medicaid Electronic Verification System (MEVS) prior to each appointment.

APPENDIX 2

NEW YORK STATE MEDICAID MTM PROGRAM

CONSENT FOR RELEASE OF MEDICAID INFORMATION TO HEALTH CARE PROVIDERS

MEDICAID MTM PILOT PROGRAM

CONSENT FOR RELEASE OF MEDICAID INFORMATION T0 HEALTH CARE PROVIDERS

Enrollee/Patient Name: ____________________________ ID Number: _________________

I understand that the purpose of the Medicaid Medication Therapy Management (MTM) Program is to help me understand the importance of my medicine in improving or maintaining my health.

By signing the consent below, if found eligible, I authorize the NYS Department of Health or its agents or contractors to release any identifiable health information about me, or about anyone for whom I can legally give consent, to physicians and/or nurse practitioners that provide me with health care services and to pharmacists participating in the MTM program that provide me with MTM services.

<u>Description of information to be accessed/received</u>: Medicaid drug and medical claims.

I understand that these claims may relate to general medical information about me, or about a person named above for whom I am able to legally give consent, including HIV/AIDS, substance abuse, mental health and genetic information.

I understand that this authorization covers the information specified above that the Medicaid Program has about me or about the person named above as of the date I sign this consent and that this consent remains in effect until such time that I revoke this consent in writing.

<u>Purpose of the use/access</u>: Medication assessment and management for me or the person named above for whom I can legally consent to receive health services.

I understand my Medicaid enrollment, eligibility for Medicaid benefits, and my eligibility to receive health care services will not be affected if I do not sign this form. This is also true for any person for whom I am legally able to consent to receive health services whose information is being shared as part of this program.

This consent is good until I notify my MTM designated pharmacy and the NYS Department of Health Medicaid MTM Program in writing of my revocation, but if I do revoke it, I understand that it will not have any effect on any actions taken by the NYS Medicaid Program or the participating providers before my revocation was received.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:

____ _______/______/______

Signature Date

Relationship to the patient: ____

MEDICAID MTM PILOT PROGRAM

Gestion des traitements médicamenteux
Consentement à la divulgation des renseignements Medicaid

Nom du bénéficiaire/patient :___________________Numéro d'identification :_________________

Je comprends que le programme de gestion des traitements médicamenteux (GTM) de Medicaid a pour but de m'aider à comprendre l'importance du rôle de mes médicaments dans l'amélioration et l'entretien de ma santé.

En signant ce formulaire de consentement, si je suis admissible, j'autorise le Département de la Santé de l'État de New York, ses agents ou représentants, à divulguer tous renseignements médicaux disponibles me concernant, ou concernant la personne dont je suis le représentant légal, aux médecins et/ou infirmiers me fournissant des services médicaux et aux pharmaciens faisant partie du programme de GTM me fournissant des services de GTM.

Description des informations fournies : médicaments et frais médicaux pris en charge par Medicaid

Je comprends que les informations ayant rapport à ces frais médicaux peuvent contenir des renseignements médicaux d'ordre général me concernant, ou concernant la personne susmentionnée dont je suis le représentant légal, y compris le VIH/sida, l'abus de substances, la santé mentale ainsi que des données d'ordre génétique.

Je comprends que ce consentement inclus les renseignements spécifiés ci-dessus que le programme Medicaid possède me concernant ou concernant la personne susmentionnée à la date de signature de ce consentement, et qu'il demeure en vigueur jusqu'à ce que j'en requiert l'annulation par écrit.

But de l'accès aux renseignements et de leur utilisation : évaluation et gestion de mes médicaments, ou des médicaments de la personne mentionnée ci-dessus pour laquelle je donne le consentement légal à recevoir des services de santé.

Je comprends que ma participation à Medicaid, mon éligibilité à recevoir des prestations de Medicaid ainsi que mon éligibilité à recevoir des services médicaux ne seront pas affectés si je ne signe pas ce formulaire. Ceci est également valable pour toute personne faisant partie de ce programme pour laquelle je donne le consentement légal à recevoir des services médicaux.

Ce consentement est valable jusqu'à ce que j'informe ma pharmacie de GTM et le Programme de GTM de Medicaid du Département de la Santé de l'État de New York par écrit de mon annulation ; je comprends également que ma décision de révoquer mon consentement n'aura aucune influence sur toute action prise par le programme Medicaid de l'État de New York ou par les prestataires participant au programme avant la réception de mon annulation.

Signature du patient ou de son représentant légal :

____ ______/_____/____
Signature Date

Lien de parenté avec le patient :____

En cas de question sur le programme, veuillez contacter le 518-486-3209

MEDICAID MTM PILOT PROGRAM

Manejo de la Terapia con Medicamentos
Autorización para revelar la información de Medicaid

Nombre del Afiliado/Paciente: ______________________ Nº de ID: _______________

Reconozco que el propósito del Programa de Manejo de la Terapia con Medicamentos (MTM) de Medicaid es ayudarme a comprender la importancia de mi tratamiento médico en el mejoramiento o mantenimiento de mi estado de salud.

Al firmar este consentimiento, si está elegible, autorizo al Departamento de Salud del Estado de Nueva York o a sus agentes o contratistas a revelar cualquier información identificable sobre mi estado de salud (o el de alguien por quien puedo dar legalmente mi consentimiento) a los médicos y/o personal sanitario que me prestan servicios de salud y a los farmacéuticos participantes en el programa MTM que me proporcionan los servicios de MTM.

<u>Descripción de la información accessible/recibida</u>: medicamentos de Medicaid y reclamaciones médicas.

Reconozco que estas reclamaciones pueden estar relacionadas con la información médica general sobre mi estado de salud, o el de la persona para la que estoy legalmente autorizado a dar mi consentimiento, incluyendo el VIH/SIDA, el abuso de sustancias, la salud mental y la información genética.

Reconozco que esta autorización cubre la información susodicha que el Programa Medicaid posee sobre mi estado de salud o el de la persona antes mencionada desde la fecha que firmo este consentimiento, y que esta autorización continuará en vigencia hasta el momento en que se revoque este consentimiento por escrito.

<u>Propósito del uso/acceso a la información</u>: evaluación y administración de los medicamentos que me han recetado a mí o a la persona por quien puedo dar legalmente mi consentimiento para recibir los servicios de salud.

Reconozco que mi afiliación a Medicaid, mi elegibilidad para las prestaciones de Medicaid y mi elegibilidad para recibir servicios de salud no se verán afectadas si no firmo este formulario. Esto también es válido para la persona por quien estoy legalmente autorizado a dar mi consentimiento para recibir servicios de salud, cuya información será compartida como parte de este programa.

Esta autorización será válida hasta que notifique por escrito su anulación a mi farmacia MTM designada y al programa Medicaid MTM del Departamento de Salud del Estado de Nueva York (NYS) pero, si la anulo, entiendo que ello no tendrá ningún efecto sobre las medidas tomadas por el Programa Medicaid del Estado de Nueva York o los proveedores participantes antes de que mi revocación sea recibida.

FIRMA DEL PACIENTE O REPRESENTANTE LEGAL:

____ _______/______/______
Firma Fecha

Relación con el paciente: ____

Las preguntas sobre el programa se pueden hacer por teléfono 518-486-3209

APPENDIX 3

NEW YORK STATE MEDICAID MTM PROGRAM

MTM CONSULTATION FORM

NEW YORK STATE MEDICAID MEDICATION THERAPY MANAGEMENT (MTM)
MTM CONSULTATION FORM

Directions to the MTM Pharmacist: Complete this form during each MTM visit. This form is a worksheet that serves as a guide to the MTM encounter. This information must be retained in the pharmacy for 6 years for audit purposes. See specific directions per section.

Patient Information:

Name:	DOB (MM/DD/YYYY):
Address, city & zip code:	Phone:
Race: (optional) – Select one: ☐ Indian/Native ☐ Alaskan ☐ Asian/Pacific ☐ Black ☐ Hispanic ☐ Caucasian ☐ Mixed ☐ Unknown	Gender: ☐ F ☐ M
Primary Care Provider (PCP), if known:	PCP Phone, if known:
Referred to South Bronx Asthma Partnership for a link to a PCP: ☐ Yes ☐ No	

MTM Pharmacist Information:

Name:	NPI:

MTM Pharmacy Information:

Name:	NPI:
Address, city & zip code:	Phone:

CIN #:______________________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: ____________

Past medical history: Chronic conditions | Acute conditions | Surgeries

____________________ ____________________ ____________________

List any Environmental and/or Occupational Exposures: ____

Family medical history: Document family history of chronic conditions for first degree relatives only, parents/siblings apply:

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Medication experience (if any): ____

Allergy Section:
For each drug or drug class, please document the reaction: Rash, Shock, Anaphylaxis, Other and Date

☐ NKDA

1) ______________________________ ☐ Rash ☐ Shock ☐ Anaphylaxis ☐ Other____________ Date ___/___/____

2) ______________________________ ☐ Rash ☐ Shock ☐ Anaphylaxis ☐ Other____________ Date ___/___/____

3) ______________________________ ☐ Rash ☐ Shock ☐ Anaphylaxis ☐ Other____________ Date ___/___/____

4) ______________________________ ☐ Rash ☐ Shock ☐ Anaphylaxis ☐ Other____________ Date ___/___/____

Adverse Drug Reaction:
For each drug or drug class, please document the reaction: Rash, Shock, Asthma, Nausea, Anemia, Other and Date

1) ______________________________ ☐ Rash ☐ Asthma ☐ Nausea ☐ Anemia ☐ Other__________ Date ___/___/____

2) ______________________________ ☐ Rash ☐ Asthma ☐ Nausea ☐ Anemia ☐ Other__________ Date ___/___/____

3) ______________________________ ☐ Rash ☐ Asthma ☐ Nausea ☐ Anemia ☐ Other__________ Date ___/___/____

4) ______________________________ ☐ Rash ☐ Asthma ☐ Nausea ☐ Anemia ☐ Other__________ Date ___/___/____

Social History:

Usage per day:

Tobacco Use: ☐ None ☐ 0-1 pack ☐ >1 pack ☐ History ☐ Exposure to second hand smoke

Caffeine Use: ☐ None ☐ <2 cups ☐ 2-6 cups ☐ >6 cups

Alcohol Use: ☐ None ☐ <2 drinks ☐ 2-6 drinks ☐ >6 drinks ☐ History of alcohol abuse

Other Relevant Social History: ____

Activity Level: ☐ Sedentary (<1 aerobic hour/week) ☐ Light (1-2.5 hours/week)

☐ Moderate (2.5 to 5 hours/week) ☐ Heavy (>5 hours/week)

Medications:
Enter medications and directions. With subsequent visits, use previous visit's notes to update medication list and then verify with the enrollee which medications are currently being taken and document any changes in directions and/or additional medications, including OTC and herbal medications, as needed. After each patient visit, medication information documented here is transferred to the Patient MTM Summary Report and the Prescriber MTM Summary Report.

1	**Medication**		**Select one:**
	Directions		☐ **Active**
	NDC (if attainable)		
	Diagnosis		☐ **Discontinued**
	Prescriber Name Address/Phone		

CIN #:______________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: ___________

2	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
3	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
4	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
5	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
6	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		

CIN #:________________________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: _____________

7	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
8	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
9	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
10	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
11	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		

CIN #:______________________________ Date of MTM Visit: ___/____/_____ Pharmacist's Initials: ____________

MM/DD/YY

12	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
13	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
14	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		
15	**Medication**		**Select one:** ☐ **Active** ☐ **Discontinued**
	Directions		
	NDC (if attainable)		
	Diagnosis		
	Prescriber Name Address/Phone		

Additional Medications:

CIN #:_______________________________ Date of MTM Visit: ___/____/_____ Pharmacist's Initials: ____________
MM/DD/YY

General Assessment: Document current status of patient's conditions/diagnoses since last MTM visit:

General Assessment of Adherence:

How many doses has the patient missed:

Today? _________________ Yesterday? ___________________ In 2 days? _________________

Past week? ______________ Past month? __________________

Primary reason(s) for missing doses:

Does the patient report feeling better/worse/no different when taking medication:

CIN #:_______________________________ Date of MTM Visit: ___/____/_____ Pharmacist's Initials: ____________

MM/DD/YY

Medication Related Problems: **Information documented here should be transferred to the Patient MTM Summary Report and the Prescriber MTM Summary Report.**

Medication(s) Name/Strength/Dose	Problem Identified	Suggested Resolution	Recommendation
Med #1 ________________ Med #2 (only fill in this line for a drug interaction) ________________	□ ADE/Allergy □ Additional therapy needed □ Adherence/compliance □ Dose change needed □ Drug interaction □ Unnecessary drug (no associated diagnosis)	□ Add medication	
		□ Change dose	
		□ Change medication	
		□ Discontinue medication	
		□ Patient education / adherence counseling	
		Notes:	
Med #1 ________________ Med #2 (only fill in this line for a drug interaction) ________________	□ ADE/Allergy □ Additional therapy needed □ Adherence/compliance □ Dose change needed □ Drug interaction □ Unnecessary drug (no associated diagnosis)	□ Add medication	
		□ Change dose	
		□ Change medication	
		□ Discontinue medication	
		□ Patient education / adherence counseling	
		Notes:	
Med #1 ________________	□ ADE/Allergy □ Additional therapy needed □ Adherence/compliance □ Dose change needed	□ Add medication	
		□ Change dose	
		□ Change medication	
		□ Discontinue medication	
		□ Patient education / adherence counseling	

CIN #:________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: ____________

Med #2 (only fill in this line for a drug interaction) ____________	□ Drug interaction □ Unnecessary drug (no associated diagnosis)	**Notes:**	
Med #1 ____________ Med #2 (only fill in this line for a drug interaction) ____________	□ ADE/Allergy □ Additional therapy needed □ Adherence/compliance □ Dose change needed □ Drug interaction □ Unnecessary drug (no associated diagnosis)	□ Add medication	
		□ Change dose	
		□ Change medication	
		□ Discontinue medication	
		□ Patient education / adherence counseling	
		Notes:	
Med #1 ____________ Med #2 (only fill in this line for a drug interaction) ____________	□ ADE/Allergy □ Additional therapy needed □ Adherence/compliance □ Dose change needed □ Drug interaction □ Unnecessary drug (no associated diagnosis)	□ Add medication	
		□ Change dose	
		□ Change medication	
		□ Discontinue medication	
		□ Patient education / adherence counseling	
		Notes:	
Med #1 ____________	□ ADE/Allergy □ Additional therapy needed	□ Add medication	
		□ Change dose	
		□ Change medication	
		□ Discontinue medication	

CIN #:______________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: __________

Med #2 (only fill in this line for a drug interaction) ______________	□ Adherence/compliance □ Dose change needed □ Drug interaction □ Unnecessary drug (no associated diagnosis)	□ Patient education / adherence counseling **Notes:**	
Med #1 ______________ Med #2 (only fill in this line for a drug interaction) ______________	□ ADE/Allergy □ Additional therapy needed □ Adherence/compliance □ Dose change needed □ Drug interaction □ Unnecessary drug (no associated diagnosis)	□ Add medication □ Change dose □ Change medication □ Discontinue medication □ Patient education / adherence counseling **Notes:**	
Med #1 ______________ Med #2 (only fill in this line for a drug interaction) ______________	□ ADE/Allergy □ Additional therapy needed □ Adherence/compliance □ Dose change needed □ Drug interaction □ Unnecessary drug (no associated diagnosis)	□ Add medication □ Change dose □ Change medication □ Discontinue medication □ Patient education / adherence counseling **Notes:**	

CIN #:______________________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: ____________

☐ Device Technique reviewed. Device/s reviewed with the patient was/were:

___

☐ Triggers reviewed and counseled on avoiding triggers. Patient's triggers are:

___

☐ Patient education provided. Handouts given to the patient were from the following resources:

___

Pharmacist's Notes:

___

CIN #:______________________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: ____________

Next Steps:

- Complete this MTM Consultation Form after each patient visit.
- Complete the Prescriber MTM Summary Report – Appendix 6 in the Provider Manual – after each patient visit. Send the Prescriber MTM Summary Report to all applicable prescribers with the appropriate cover letter (appendix 7 for initial visit and appendix 8 for subsequent visits) within 2 business days of the patient visit.
- Complete the Patient MTM Summary Report – Appendix 5 in the Provider Manual – and provide a copy to the patient at the end of each patient visit or via mail within 2 business days of the MTM visit.
- Fax the MTM Consultation Form, the Prescriber MTM Summary Report and the Patient MTM Summary Report to the New York State Medicaid MTM Program within 2 business days of the patient visit:

SUNY at Buffalo
School of Pharmacy & Pharmaceutical Sciences
Attn: NYS Medicaid MTM Forms
1-877-779-5654

Appointment Information:

☐ Initial Visit ☐ Subsequent Visit	
Start time:	End time:

MTM Pharmacist Name: ______________________________
(please print)

MTM Pharmacist's Signature: ______________________________

CIN #:______________________ Date of MTM Visit: ___/____/_____ MM/DD/YY Pharmacist's Initials: ____________

APPENDIX 4

NEW YORK STATE MEDICAID MTM PROGRAM

POST-VISIT PHARMACIST TASKS

POST-VISIT PHARMACIST TASKS

1. At the end of the visit, the MTM pharmacist should document all the encounter information and provide the following assistance to the enrollee.

    a. Patient demographics (reconciliation)
    b. Medication reconciliation
    c. Review of drug delivery techniques
    d. Review of triggers and trigger avoidance
    e. Specific education handouts provided to the patient
    f. Next appointment date
    g. Possible medication adjustments, if needed, to be discussed with the PCP
    h. If lack of PCP, assistance in finding one/referral
    i. Specific topics to be discussed at next visit.

2. Provide a Patient MTM Summary Report (Appendix 5) to the patient, either at the conclusion of the visit or by mail to the patient within two business days of the visit.

3. Provide Prescriber MTM Summary Report (Appendix 6) with appropriate cover letter (Appendix 7 for initial visit or Appendix 8 for subsequent visits) to the medical provider via mail or secure fax. If medication changes are recommended, a follow-up call to the prescribers office is required to discuss recommendations and patient's progress

4. Fax the MTM Consultation Form, the Prescriber MTM Summary Report and the Patient MTM Summary Report to the New York State Medicaid MTM Program within 2 business days of the patient visit.

    SUNY at Buffalo
    School of Pharmacy & Pharmaceutical Sciences
    Attn: NYS Medicaid MTM Forms
    1-877-779-5654

If making medication recommendations, check the NYS Medicaid Preferred Drug List (PDL) first. Use the following to access the PDL.
http://nyhealth.gov/health_care/Medicaid/program/pharmacy.htm

- Go to the Medicaid Pharmacy Preferred Drug Program link on that screen - or –
- Go to the https://newyork.fhsc.com/providers/PDP_about.asp webpage

POST-VISIT PHARMACIST CHECKLIST

At the end of the visit, the MTM pharmacist should document all the encounter information and provide the following assistance to the enrollee.

- ☐ Patient demographics (reconciliation)
- ☐ Medication reconciliation
- ☐ Review of drug delivery techniques
- ☐ Review of triggers and trigger avoidance
- ☐ Specific education handouts provided to the patient
- ☐ Next appointment date
- ☐ Possible medication adjustments, if needed, to be discussed with the PCP
- ☐ If lack of PCP, assistance is finding one/referral
- ☐ Specific topics to be discussed at next visit
- ☐ Provide a Patient MTM Summary Report (Appendix 5) to the patient, either at the conclusion of the visit or by mail to the patient within two business days of the visit.
- ☐ Provide Prescriber MTM Summary Report (Appendix 6) with appropriate cover letter (Appendix 7 for initial visit or Appendix 8 for subsequent visits) to the medical provider via mail or secure fax. If medication changes are recommended, a follow-up call to the prescriber's office is required to discuss recommendations and patient's progress.
- ☐ Fax the MTM Consultation Form, the Prescriber MTM Summary Report and the Patient MTM Summary Report to the New York State Medicaid MTM Program within 2 business days of the patient visit.

SUNY at Buffalo
School of Pharmacy & Pharmaceutical Sciences
Attn: NYS Medicaid MTM Forms
1-877-779-5654

If making medication recommendations, check the NYS Medicaid Preferred Drug List (PDL) first. Use the following to access the PDL.
http://nyhealth.gov/health_care/Medicaid/program/pharmacy.htm

- Go to the Medicaid Pharmacy Preferred Drug Program link on that screen - or –
- Go to the https://newyork.fhsc.com/providers/PDP_about.asp webpage

APPENDIX 5

NEW YORK STATE MEDICAID MTM PROGRAM

PATIENT MTM SUMMARY REPORT

NEW YORK STATE MEDICAID MEDICATION THERAPY MANAGEMENT (MTM)
PATIENT MTM SUMMARY REPORT: MEDICATION RECORD AND ACTION PLAN

Patient Name:	DOB (MM/DD/YYYY):

Drug Name & Strength	Directions	What I take this medication for (condition):	When I take this medication:				Special Instructions	Prescriber
			Morning	Noon	Evening	Bedtime		

CIN #: ___________________________ Date of MTM Visit: ____/____/_____ (MM/DD/YY) Pharmacist Initials: ____________

Action Steps for Patient:

Notes for Patient:

MTM Pharmacist and Pharmacy Information:

Pharmacist Name:	NPI:
Pharmacy Name and Address:	Phone:

Primary Care Provider (PCP):	PCP Phone, if known:

Next appointment Date: ______/______/______ Time: ____:____ AM PM Location: ______________________________
MM/DD/YYYY

MTM Pharmacist Name: ____
(please type)

MTM Pharmacist's Signature: ____

CIN #: ___________________________ Date of MTM Visit: ____/____/_____ (MM/DD/YY) Pharmacist Initials: ____________

APPENDIX 6

NEW YORK STATE MEDICAID MTM PROGRAM

PRESCRIBER MTM SUMMARY REPORT

MTM Pharmacist: Please use the note in the Evaluation, Summary and Recommendation section. Customize where appropriate with patient-specific information.

NEW YORK STATE MEDICAID MEDICATION THERAPY MANAGEMENT (MTM) PRESCRIBER MTM SUMMARY REPORT

Patient name (first, last): ____

Medicaid ID # (CIN #): ______________________ DOB (MM/DD/YYYY): ___/___/_____

________________________ is enrolled in and receiving Medication Therapy Management (MTM) services to
(*PATIENT FULL NAME*)
help improve his/her medication adherence and health outcomes. MTM services are being administered by
__________________________, _________________.
(PHARMACY NAME, PHARMACY NPI #)

Medication List	
1.	**9.**
2.	**10.**
3.	**11.**
4.	**12.**
5.	**13.**
6.	**14.**
7.	**15.**
8.	**16.**

Summary and Recommendations

	Drug Therapy Problem	Related Condition	Recommendation
1			
2			
3			
4			
5			
6			

MTM Pharmacist: ________________________________ RPh NPI: ______________________

MTM Pharmacy Address: ____

MTM Pharmacy Phone:____

MTM Pharmacy Fax:____

CIN #:____________ Date of MTM Visit: ____/____/____ Pharmacist's Initials: __________
MM/DD/YY

MTM Visit: Detailed Summary

A comprehensive assessment of this patient's drug-related needs was conducted. The following are identified drug therapy problems and recommended solutions.

Drug Therapy Problem #1:

____
(CONDITION)

____
(DRUG THERAPY PROBLEM, RECOMMENDED CHANGES, AND RECOMMENDED SOLUTION)

Drug Therapy Problem #2:

____
(CONDITION)

____
(DRUG THERAPY PROBLEM, RECOMMENDED CHANGES, AND RECOMMENDED SOLUTION)

Drug Therapy Problem #3:

____
(CONDITION)

____
(DRUG THERAPY PROBLEM, RECOMMENDED CHANGES, AND RECOMMENDED SOLUTION)

Drug Therapy Problem #4:

____
(CONDITION)

____

CIN #:_____________ Date of MTM Visit: ____/____/____ Pharmacist's Initials: ___________
MM/DD/YY

(*DRUG THERAPY PROBLEM, RECOMMENDED CHANGES, AND RECOMMENDED SOLUTION)*

Drug Therapy Problem #5:

____
(CONDITION)

____
(*DRUG THERAPY PROBLEM, RECOMMENDED CHANGES, AND RECOMMENDED SOLUTION)*

Drug Therapy Problem #6:

____
(CONDITION)

____
(*DRUG THERAPY PROBLEM, RECOMMENDED CHANGES, AND RECOMMENDED SOLUTION)*

ADDITIONAL ENCOUNTER NOTES:

Goals established during our visit:

1.

2.

3.

_____________________________'s next MTM appointment is scheduled for ____ /____/ ____.
(PATIENT FULL NAME) *(DATE, MM/DD/YYYY)*

If you have any questions or comments regarding these goals or recommendations, please call me at

_________________________, _____-_____-________.
(PHARMACY NAME, PHONE NUMBER)

CIN #:_____________ Date of MTM Visit: ____/____/____ Pharmacist's Initials: ___________
MM/DD/YY

Allergies:

☐ NKDA

Medication	Reaction

Adverse Drug Reactions/Intolerances:

☐ None

Medication	Reaction

MTM Pharmacist Name: ____
(please print)

MTM Pharmacist's Signature: ____

For more information on the NYS Medicaid MTM Pilot program, please visit:
http://nyhealth.gov/health_care/medicaid/program/mtm/index.htm

CIN #:______________ Date of MTM Visit: ____/____/____ Pharmacist's Initials: ____________
MM/DD/YY

APPENDIX 7

NEW YORK STATE MEDICAID MTM PROGRAM

INITIAL PRESCRIBER COMMUNICATION COVER LETTER

THIS FORM ACCOMPANIES THE PRESCRIBER MTM SUMMARY REPORT WHEN IT IS SENT TO A PRESCRIBER FOR THE FIRST TIME FOR THAT ENROLLEE. CUSTOMIZE WHERE APPROPRIATE WITH PATIENT SPECIFIC INFORMATION.

NEW YORK STATE MEDICAID MEDICATION THERAPY MANAGEMENT (MTM)

____
(PRESCRIBER NAME)

____
(ADDRESS)

____________________ ____________ ____________
(CITY) (STATE) (ZIP)

Dear ____________________________,
(PRESCRIBER NAME)

You are receiving this letter because your patient, ______________________, ____/____/______
(PATIENT NAME) (PATIENT DOB, MM/DD/YY)
is enrolled in the Medicaid Medication Therapy Management (MTM) program and has received Medicaid MTM services. The Medicaid MTM program is a medication-focused service provided by qualified MTM pharmacists designed to foster communication between patients, prescribers and the pharmacist. The program is intended to improve patient adherence to drug therapy and improve therapeutic outcomes.

Attached for your information is:

- A Fact Sheet explaining the Medicaid MTM Program
- A list of current medications, as related by __________________________
  (PATIENT NAME)
- A summary report of ________________'s Medicaid MTM encounter on _____/____/______
  (PATIENT NAME) (VISIT DATE, MM/DD/YY)

The summary report may contain patient specific medication recommendations. If you have questions regarding information contained in this report, please contact me directly at _____-_____-________________________.
(PHARMACIST PHONE NUMBER)

__________________________'s next scheduled appointment for Medicaid MTM services is:
(PATIENT NAME)
___/___/_____ at _________ ⌂ AM ⌂ PM.
(MM/DD/YYYY)

For more information on the Medicaid MTM program, please visit the Medicaid Pharmacy web site at: http://nyhealth.gov/health_care/medicaid/program/pharmacy.htm. If you have any MTM program questions, please call 1-877-779-5653 or email nymtm@nysdoh.suny.edu.

I hope you find this service a valuable addition to your patient's plan of care.

Sincerely,

____
(MTM RPH NAME)

____
(PHARMACY)

____
(ADDRESS)

_______-________-__________
(PHONE)

_______-________-__________
(FAX)

Medication Therapy Management
Information for Prescribers

Medication Therapy Management (MTM) is a medication-focused service provided by a qualified pharmacist intended to improve patient adherence to drug therapy and improve therapeutic outcomes.

NYS Medicaid Medication Therapy Management Program

NYS Medicaid has been authorized to offer this service to qualified Medicaid enrollees. Patients who choose to enroll in the program will meet with a qualified MTM pharmacist one-on-one, face-to-face to discuss topics such as current medication regimen, symptom management, and strategies for controlling chronic conditions.

Initially, this program is being piloted in the Bronx. Therefore, only select Medicaid enrollees residing in the Bronx are eligible for this program.

Medicaid MTM Supports Prescribers

There is no paperwork required from prescribers. The program is designed to support prescribers by:

- Optimizing patient response to medication and adherence to treatment plan
- Managing medication-related interactions or complications
- Fostering communication between patients, prescribers and the pharmacist
- Serving as a clinical pharmacy resource for prescribers

Prescribers with patients who participate in this program will receive:

- Current list of all medications taken by the patient
- Patient reports from the MTM pharmacist
- Alerts of potential medication interactions and suggested recommendations
- Support services from the MTM pharmacist as a clinical pharmacy resource

Medicaid MTM is a Free Service for Qualified NYS Medicaid Enrollees

There is no cost to qualified NYS Medicaid enrollees, pharmacists, or prescribers who are involved in the Medicaid MTM program. Questions regarding the program can be directed to 1-877-779-5653 or by email to nymtm@nysdoh.suny.edu.

APPENDIX 8

NEW YORK STATE MEDICAID MTM PROGRAM

SUBSEQUENT PRESCRIBER COMMUNICATION COVER LETTER

THIS LETTER ACCOMPANIES THE PRESCRIBER MTM SUMMARY REPORT FOR SUBSEQUENT COMMUNICATIONS WITH A PRESCRIBER. CUSTOMIZE WHERE APPROPRIATE WITH PATIENT SPECIFIC INFORMATION.

NEW YORK STATE MEDICAID MEDICATION THERAPY MANAGEMENT (MTM)

____
(PRESCRIBER NAME)

____
(ADDRESS)

_______________ _______ __________
(CITY) (STATE) (ZIP)

Dear _____________________________,
(PRESCRIBER NAME)

The purpose of this letter is to report the findings of my MTM visit with

__________________________ _______________ on ____/____/______.
(PATIENT NAME, PATIENT DOB, MM/DD/YYYY) (DATE OF MTM VISIT)

Attached is a copy of the MTM encounter summary report for

_____________________'s visit and a complete medication record as related by the
(PATIENT NAME)

patient. **The summary report may contain patient specific medication recommendations.**

If you have questions regarding information contained in this report, please contact me directly at __________________________________.
(PHARMACIST PHONE NUMBER)

______________________'s next scheduled appointment for Medicaid MTM services is:
(PATIENT NAME)

____/____/_______ at ___:____ AM PM.
(MM/DD/YYYY)

For more information on the Medicaid MTM program, please visit the Medicaid Pharmacy web site at: http://nyhealth.gov/health_care/medicaid/program/pharmacy.htm. If you have any MTM program questions, please call the New York State Medicaid MTM Program at 1-877-779-5653 or email nymtm@nysdoh.suny.edu.

I hope you find this service a valuable addition to your patient's plan of care.

Sincerely,

____
(MTM RPH NAME)

____
(PHARMACY)

____
(ADDRESS)

____
(PHONE)

____
(FAX)

APPENDIX 9

NEW YORK STATE MEDICAID MTM PROGRAM

CHANGE OF PHARMACY OR PHARMACIST REQUEST FORM

MEDICAID MTM PILOT PROGRAM

CHANGE OF PHARMACY or PHARMACIST Request Form

Directions:
If a Medicaid enrollee requests a change in MTM pharmacy or Pharmacist, complete page 1of this form and **disregard** page 2.

If a Medicaid MTM Pharmacist is requesting a change in pharmacy location (Bronx only), complete page 2 of this form **only**.

Medicaid Enrollee Request:

Name of Medicaid Enrollee: ____

Medicaid Enrollee ID (CIN) Number: ____

Reason for change (Select one):

A. Requesting different MTM Pharmacy
B. Requesting different MTM Pharmacist
C. Other____

If known, name and address of preferred new pharmacy for MTM services: ____

____

____

If unknown, what general Bronx location/address does the patient prefer? ____

____

____

Fax to: SUNY at Buffalo
School of Pharmacy & Pharmaceutical Sciences
Attn: NYS Medicaid MYM Forms
1-877-779-5654

OR

Mail to:
SUNY at Buffalo
School of Pharmacy & Pharmaceutical Sciences
Attn: NYS Medicaid MTM Forms
Hochstetter 311
Buffalo, NY 14260

MEDICAID MTM PILOT PROGRAM

CHANGE OF PHARMACY or PHARMACIST Request Form

Directions:
If a Medicaid enrollee requests a change in MTM pharmacy or Pharmacist, complete page 1of this form and **disregard** page 2.

If a Medicaid MTM Pharmacist is requesting a change in pharmacy location (Bronx only), complete page 2 of this form **only**.

Pharmacist Request

Pharmacist NPI Number:

____

Current Pharmacy Name and Address:

____

If applicable, new location of employment:

Name: ____

Address: ____

____

Phone: ____

NPI: ____

Please select one:

☐ New pharmacy is a Medicaid MTM pharmacy and I would like to continue to offer MTM services at this pharmacy.

☐ New pharmacy is NOT a Medicaid MTM pharmacy but and I would like to continue to offer MTM services at this pharmacy.

☐ New pharmacy is NOT a Medicaid MTM pharmacy and not interested in offering MTM services

☐ Do not know if the new pharmacy is offering MTM services

Fax to: SUNY at Buffalo
School of Pharmacy & Pharmaceutical Sciences
Attn: NYS Medicaid MTM Forms
1-877-779-5654

OR

Mail to: SUNY at Buffalo
School of Pharmacy & Pharmaceutical Sciences
Attn: NYS Medicaid MTM Forms
Hochstetter 311
Buffalo, NY 14260

APPENDIX 10

NEW YORK STATE MEDICAID MTM PROGRAM

RESOURCES AND REFERENCES

RESOURCES AND REFERENCES

Additional MTM Training:

- American Pharmacists Association www.pharmacist.com
- University of Minnesota Continuing Education: Building a Medication Therapy Management Practice Online course: http://ce.pharmacy.umn.edu/courses/mtm_long.html
- National Association of Chain Drug Stores www.nacds.org

Resources for MTM Pharmacists

Please note: these web links listed here may change. For most current links, please refer to the organizations website directly.

New York State Department of Health
General Website http://nyhealth.gov
Medicaid Pharmacy Program http://nyhealth.gov/health_care/medicaid/program/pharmacy.htm
Medicaid Pharmacy Program – eMedNY http://www.emedny.org/info/index.html
Medicaid Pharmacy Program – eMedNY – Formulary File http://www.emedny.org/info/formfile.html
Medicaid Pharmacy Program – Preferred Drug Program (PDP) https://newyork.fhsc.com/providers/PDP_about.asp
Medicaid Pharmacy Program – Preferred Drug List (PDL) https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf
Medicaid Update http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm
General
NYC Toolkits http://www.nyc.gov/html/doh/html/csi/csi-detailing.shtml#phkit
State Link http://www.health.state.ny.us/diseases/
Asthma
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/prof/lung/index.htm#asthma
Centers for Disease Control and Prevention http://www.cdc.gov/ASTHMA/healthcare.html
American Lung Association http://www.lungusa.org/lung-disease/asthma/
New York State Department of Health http://www.health.state.ny.us/diseases/asthma/

New York City Department of Health and Mental Hygiene http://www.nyc.gov/html/doh/html/csi/csi-asthmakit.shtml
CHF
American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3004550 or www.heart.org
New York State Department of Health – Cardiovascular Disease http://www.nyhealth.gov/diseases/cardiovascular/heart_disease/
Heart Failure Society of America http://www.hfsa.org/hf_guidelines.asp
COPD
The Global Initiative for Chronic Obstructive Lung Disease http://www.goldcopd.com/Guidelineitem.asp?l1=2&l2=1&intId=2003
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/public/lung/copd/health-care-professionals/index.htm
New York State Department of Health http://www.health.state.ny.us/diseases/chronic/copd/fact_sheet.htm
American Lung Association http://www.lungusa.org/lung-disease/copd/
Diabetes
American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3004603 or www.heart.org
American Diabetes Association http://professional.diabetes.org/CPR_search.aspx
Diabetes Care-Journal http://care.diabetesjournals.org/content/32/1/193.full.pdf+html
National Kidney Foundation http://www.kidney.org/
New York State Department of Health – Diabetes http://www.health.state.ny.us/diseases/conditions/diabetes/
New York State Department of Health – Diabetes - Toolkit http://www.health.state.ny.us/diseases/conditions/diabetes/toolkit_descriptions.htm

New York City Department of Health and Mental Hygiene http://www.nyc.gov/html/doh/html/csi/csi-diabeteskit.shtml
Hypercholesterolemia
American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3004583 or www.heart.org
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/prof/heart/index.htm#chol
New York City Department of Health and Mental Hygiene http://www.nyc.gov/html/doh/html/csi/csi-cholkit.shtml
Hypertension
American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3004556 or www.heart.org
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/prof/heart/index.htm#hbp
New York City Department of Health and Mental Hygiene http://www.nyc.gov/html/doh/html/csi/csi-hyperkit.shtml
Migraine
American Academy of Neurology http://www.neurology.org/cgi/reprint/55/6/754.pdf
American Headache Society https://www.americanheadachesociety.org/professionalresources/USHeadacheConsortiumGuidelines.asp
Myocardial Infarction
American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3004562 or www.heart.org
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/prof/heart/index.htm#ami
Smoking Cessation
Centers for Disease Control and Prevention http://www.cdc.gov/tobacco/
Health and Human Services-Public Health Service http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3004591 or www.heart.org
American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3018961 or www.heart.org
American Lung Association http://www.lungusa.org/stop-smoking/
American Cancer Society http://www.cancer.org/Healthy/StayAwayfromTobacco/GuidetoQuittingSmoking/index?from=fast
New York City Department of Health and Mental Hygiene http://www.nyc.gov/html/doh/html/csi/csi-tobaccokit.shtml
New York State Department of Health – Tobacco Control Program http://nyhealth.gov/prevention/tobacco_control/
New York State Department of Health – Tobacco Control Program - Smoker's Quitline http://www.nysmokefree.com
Stroke
American Heart Association http://www.americanheart.org/presenter.jhtml?identifier=3004586 or www.heart.org
National Institute of Neurological Disorders and Stroke http://www.ninds.nih.gov/disorders/stroke/stroke.htm
National Stroke Association http://www.stroke.org/site/PageServer?pagename=MEDPRO
New York State Department of Health – Cardiovascular Disease http://www.health.state.ny.us/publications/1622.pdf http://www.health.state.ny.us/diseases/cardiovascular/stroke/resources.htm

Resources for Patient Education Materials for NYS Medicaid MTM Pilot Program

Please note: these web links listed here may change. For most current links, please refer to the organizations website directly.

General Website	Comment
http://nyhealth.gov	
Multiple Disease References	**Comment**
The World Health Organization http://www.who.int/topics/chronic_diseases/factsheets/en/index.html	Multiple languages Higher reading level
Centers for Disease Control and Prevention http://www.cdc.gov/DiseasesConditions/	
Asthma	
New York State Department of Health http://www.health.state.ny.us/diseases/asthma/asthma_faqs.htm	
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/public/lung/index.htm#asthma	
American Pharmacists Association www.pharmacist.com	Pharmacy Practice → Patient Care Services → Patient Education Brochures
American Pharmacists Association http://www.pharmacist.com/AM/Template.cfm?Section=Patient_Care_Services2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=17734	How to use your inhaler in English and Spanish
Cardiovascular (Hypercholesterolemia, Hypertension, MI, Obesity and Physical Activity)	
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/index.htm	Information on Heart and Vascular Diseases, Lung Diseases, Blood Diseases, Sleep Disorders
National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/public/heart/index.htm	Cholesterol, obesity and weight loss, blood pressure. Includes

	some Spanish handouts and risk calculators
Diabetes	
American Diabetes Association http://www.diabetes.org	General information, not medication or pharmacist focused
American Diabetes Association http://www.diabetes.org/living-with-diabetes/	Web tools to use with patients or to direct patients to
American Diabetes Association http://www.diabetes.org/food-and-fitness/food/	Nutrition information
Flu	
Centers for Disease Control and Prevention http://www.cdc.gov/flu/professionals/patiented.htm	Fact sheet Available in Spanish and Chinese
Resources about taking medications	**Comment**
Institute for Safe Medication Practices http://www.ismp.org/consumers/safemeds.pdf	17 pages, PDF, general medication use
Institute for Safe Medication Practices http://www.ismp.org/consumers/brochure.asp	General information on medication safety
American Pharmacists Association Foundation http://www.pharmacyandyou.org/	Use: How Your Pharmacist Helps You and Managing Your Health
National Council on Patient Information and Education http://www.talkaboutrx.org/med_users_tools.jsp	General information on how to take meds – prescription and OTC.
National Council on Patient Information and Education http://www.bemedwise.org/index.html http://www.bemedwise.org/brochure/bemedwise_english_brochure.pdf	All OTC medications Includes how to read a label, tips for parents Available in Spanish
WebMD http://www.webmd.com/drugs/index-drugs.aspx	Reference for patients and pharmacists. Search for info on specific drugs. FDA partner with WebMD

APPENDIX 11

MEDICAID MTM PILOT PROGRAM

PATIENT MEDICATION SCHEDULE

Directions to the MTM Pharmacist on Completing the Medication Schedule

This weekly grid is meant to be a tool for patients who take multiple medications at multiple times per day. It is to be used as a weekly reference for the patient to help a patient improve adherence.

In the Medication/Directions column: Enter the medications and directions for the each medication that the patient takes in the morning, afternoon, evening, at bedtime, and as directed/ as needed.

In the Time column: Based upon your discussion with the patient, write what time the patient takes that particular medication. Example: A morning dose for 1 patient may be
7 AM; however a morning dose for a different patient may be 10 AM. For each medication, enter the time that is most appropriate for the patient, as well as best aligned with their schedule.

In the Monday-Sunday columns: Enter X or a check mark to indicate which days of the week that the patient should take the medication.

Instruct the patient to bring this to each MTM visit as well as each appointment with a medical provider.

NEW YORK STATE MEDICAID MEDICATION THERAPY MANAGEMENT (MTM)
MEDICATION SCHEDULE

Patient name: ___________________________

	Medication & Directions	Time	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning									
Afternoon									
Evening									
Bedtime									
As directed/ As needed									

CIN #:_______________________________Date of MTM Visit: ____/__/______ MTM Pharmacist's Name: ____________________________
(MM/DD/YY) MTM Pharmacy: ___________________________

APPENDIX 12

NEW YORK STATE MEDICAID MTM PROGRAM

MISSED APPOINTMENT FORM

MISSED APPOINTMENT FORM

Directions to the MTM Pharmacist: If a patient misses their scheduled MTM visit and does not call the pharmacy in advance to reschedule and is a "No Show", the MTM Pharmacist should document that information on this form. Use this form to document the outreach to the patient.

Once the patient has been contacted and the appointment rescheduled or if the outreach to the patient fails (3 telephone attempts within 5 days of the missed appointment), this form should be faxed to the New York State Medicaid MTM Program at 1-877-779-5654.

Patient information

Name:	**DOB:**
CIN #:	
Date of Missed Appointment:	
Phone Number Attempted to Contact the Patient:	

Date and Outcome of Call Attempts	
Date	**Outcome**
1)	
2)	
3)	

MTM Pharmacist Name: ____
(please print)
MTM Pharmacist NPI Number:____

MTM Pharmacist's Signature:_______________________________________

Date:____

MTM Pharmacy Name:____

MTM Pharmacy NPI:____