JHM Outpatient Medication Assistance Program

Description and Application

Instructions: Download and read this form. Complete the application and email to policy@jhmi.edu. Please put “OMAP” in the subject line.

Purpose
To reduce ethical conflicts of interest raised by pharmaceutical samples, as of July 1, 2011 Johns Hopkins Medicine outpatient clinics are not permitted to accept or distribute industry-supplied medication samples or industry-supplied medication vouchers. (There are exceptions for samples needed to teach patients how to administer medications. See http://www.hopkinsmedicine.org/Research/OPC/Policy_Industry_Interaction/.) Some JHM outpatient clinics have used drug samples for uninsured patients. To provide these patients short-term access to medications while they are in the process of obtaining sustained coverage, JHM has initiated an Outpatient Medication Assistance Program (OMAP) for qualifying clinics.

Key features of the OMAP are as follows:
- Clinics must complete an application and be approved to participate.
- Patients must have a documented need.
- Generic medications are covered; brand-name medications are covered when no generic or therapeutic alternative exists.
- Each clinic must assign a specific individual responsibility for oversight and compliance with institutional requirements.

Terms and Conditions
Once a clinic’s participation has been approved, the clinic physicians (or other prescribers) may identify uninsured patients with financial need -- for example, patients who have no insurance coverage for medication, are awaiting enrollment in Medical Assistance, have applied to participate in manufacturers’ patient assistance programs but have not yet been accepted, and/or cannot access low-cost medications at retail outlets. (A tool for assessing patient need will be provided to participating clinics.) The physician must document each patient’s need in the chart, and clinic staff will separately document their screening of patients for financial need. The physician will write a prescription and give the patient a specially-marked voucher. The patient will take the prescription and voucher to any Johns Hopkins Outpatient Pharmacy. The prescription will be filled at no charge to the patient. For clinics located at a distance from the Johns Hopkins Outpatient Pharmacies, the program will work with clinics to try to arrange for delivery of medication.

Prescriptions must be written for generic medications. If no generic version of the drug of choice exists, the physician should prescribe a therapeutic equivalent as long as the equivalent is appropriate. If there is no generic version or appropriate therapeutic equivalent available, a branded medication may be prescribed. There will be routine review of prescriptions for branded medications to determine whether generics could be prescribed instead, and, if not, whether the cost of branded medications can be sustained. There will be a per-patient limit of up to one 30-day supply per prescription per year. Exceptions will be considered on a case-by-case basis where there is documented need.

During the first year of the Program, there will be no charge to participating clinics. Utilization will be closely monitored.

Clinics must agree to actively counsel needy patients about access to discounted medications at retail outlets, including the Johns Hopkins Outpatient Pharmacy; help them enroll in Medical Assistance or other insurance programs; assist in enrolling them in drug manufacturers’ patient assistance programs; and provide them financial management counseling in support of medication access.

Participating clinics will be required to track data such as the number of patients served; number of prescriptions written to the program; and specific prescription information. The Outpatient Pharmacy will send participating clinics monthly usage reports. Clinics must follow up on patients who fail to fill their prescriptions.

Clinics’ eligibility for the program will be reviewed annually.
1) Clinic name

2) Clinic address

3) Clinic phone number

4) Clinic fax number

5) Clinic number if applicable

6) Name and title of Medical Director

7) Email and phone number of Medical Director

8) Name and title of responsible staff member in the clinic (may be the clinic coordinator, a physician, other health care professional, social worker, etc.). This individual must be assigned responsibility for adhering to OMAP requirements and will be the primary clinic contact for the Program.

9) Email and phone number of responsible staff member (e.g., clinic coordinator)

10) Why are you applying to participate in OMAP and how do you expect it to impact your clinic? Be as specific as possible.

11) Approximately how many of your clinic’s uninsured patients do you anticipate will be served under the OMAP each month?

12) Approximately how many different types of prescriptions does each of these patients need?

13) For which medications did industry previously give your clinic samples or vouchers? List brand names.
   a. __________________
   b. __________________
   c. __________________
   d. __________________
   e. __________________
   f. __________________
   g. __________________
   h. __________________
   i. __________________
   j. __________________

14) If your patients cannot travel to a Johns Hopkins Outpatient Pharmacy, we will work with you to try to arrange for delivery of medications, either on a regular shipment basis or a per-prescription basis. Please answer the following questions.
   a. Does your clinic have uninsured patients who are unable to travel to a Johns Hopkins Outpatient Pharmacy?
   b. If these patients’ medications were shipped to the clinic, would the clinic be willing to appropriately receive, store and hand the medications to the patients?
   c. Would home delivery of medications be necessary for some of these patients?
   d. Would your clinic be willing to pay for shipment of medication to the clinic or the patient’s home?
If this application is approved, we agree to meet the conditions associated with the Outpatient Medication Assistance Program.

Signatures (you may sign electronically)

________________________  _________________________
Medical Director                    Date

________________________  _________________________
Responsible Staff Member            Date

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