

# University of Colorado Hemophilia Center Pharmacy

## PATIENT HANDOUTS

The following documents are intended to inform you of your rights as a patient. Listed below are the handouts provided in each packet:

- 📎 Welcome Letter
- 📎 Patient Rights and Responsibilities
- 📎 HIPAA Notice of Privacy Practices
- 📎 Grievance/Complaint Reporting
- 📎 Safe Handling of Medication
- 📎 Medication Storage
- 📎 Drug Disposal Guidelines
- 📎 Sharps Disposal Guidelines
- 📎 Release of patient health information form (Sign and return to HTC Pharmacy)
- 📎 Patient Authorization and Plan of Service (Sign and return to The University of Colorado HTC Pharmacy)
- 📎 Patient Satisfaction Survey
- 📎 Important information
- 📎 Self-addressed envelope

**\*\*\*For uninterrupted service, please sign and return the “Patient Authorization and Plan of Service Form” and “ PHI Release Form” in the provided self-addressed envelope. \*\*\***

**Thank you for choosing The University of Colorado Hemophilia Center Pharmacy**

# The University of Colorado Hemophilia Center Pharmacy

## The University of Colorado Hemophilia Center Pharmacy

**We are pleased you have chosen us to partner with you in the management of your healthcare.**

**The University of Colorado HTC Pharmacy** understands that managing your condition is the highest priority. Following a prescribed course of treatment is not always easy, especially for those with chronic conditions. We appreciate the opportunity to build a relationship of trust, commitment and quality to assist you. By collaborating with your prescribing physician, **The University of Colorado HTC Pharmacy** pharmacists can more effectively assist you in managing your medication and condition; while improving your outcomes.

### **Benefits of our patient management program services:**

- ✓ **The University of Colorado HTC Pharmacy's** patient management program benefits include increasing compliance, managing side effects, and overall improvement of health.
- ✓ **Personalized patient care** - **The University of Colorado HTC Pharmacy** prides itself in supplying patients with a high level of personalized patient care from insurance verification to prompt accurate free delivery of your medications. Our highly skilled staff of professionals is dedicated to providing you with the highest quality of care when you most need it.
- ✓ **Integrated Services** - We work directly with the HTC providers, nurses and physical therapists to ensure that any challenges you may be having with your treatment are addressed immediately with your providers.
- ✓ **24/7 Support-** **The University of Colorado HTC Pharmacy** patients receive prompt professional service, trained pharmacists are available for you 24 hours a day, 7 days a week, 365 days a year for emergency factor medication concerns. For life threatening medical emergencies call 911.
- ✓ **Regular follow-up** – Getting your medications and medical supplies quickly and efficiently is important. We will follow up with you frequently to address any needs that you may have.
- ✓ **Delivery** – We offer fast and convenient delivery to your home, workplace, or a location of your choice. A member of the pharmacy team will contact you 5-7 days prior to your refill due date to coordinate your factor and infusion supply needs, update your medical and insurance records, and to set up and confirm a delivery date and location.
- ✓ **Insurance** – Hemophilia treatment is costly; we will help you navigate through the complexities of the healthcare system to find the best options for you. Our relationships with insurers will help provide you with information and explanation of your prescription and medical insurance benefits. Will inform you of any financial responsibilities, including out of pocket costs, co-pays, and deductibles.
- ✓ **If we are deemed an out of network pharmacy-, we will provide you in writing any out of pocket cost.**

**Limitations:** Our services are limited to the products and services we provide.

**The University of Colorado  
Hemophilia Center Pharmacy  
13199 East Montview Blvd.  
Ste 100**

**Aurora, CO 80045**

**303-724-0168**

**Fax: 303-724-0848**

**[hemophilia@ucdenver.edu](mailto:hemophilia@ucdenver.edu)**

**Pharmacy Hours**

**Monday – Friday 8:30 AM to 4:30 PM**

(Pharmacist available after hours, weekends, and holidays)



## **PATIENT BILL OF RIGHTS AND RESPONSIBILITIES**

### **As our patient, you have the right to:**

1. Choose a pharmacy service provider.
2. Choose a health care provider, including choosing an attending physician, if applicable.
3. Be fully informed in advance about service/care to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care.
4. Participate in the development and periodic revision of the plan of service/care.
5. The right to decline participation, revoke consent, or un-enroll at any point in time including the refusal of care or treatment after the consequences of refusing care or treatment are fully presented.
6. Be informed, both orally and in writing, in advance of service/care being provided, of the charges, including payment for service/care expected from third parties, and any charges for which the patient will be responsible.
7. To know about the philosophy and characteristics of the patient management program.
8. To receive the appropriate or prescribed services in accordance with physician orders and in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap.
9. To have one's property and person treated with friendliness, courtesy and respect by each and every individual representing our Pharmacy, who provide treatment or services for you and be free from neglect or abuse, be it physical or mental.
10. To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services.
11. To receive treatment and services within the scope of your plan of care and to receive information on the specific limitations of those services, promptly and professionally, while being fully informed as to our Pharmacy's policies, procedures, and charges
12. To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs.
13. To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans.
14. To request and receive data regarding treatment, services, or costs thereof, privately and with confidentiality.
15. To express, concerns, grievances/complaints or recommend modifications to your Pharmacy in regards to treatment or care and to have those grievances/complaints investigated in a timely manner and without fear of discrimination or reprisal
16. To receive information on handling drug recall.
17. To receive information about the patient management program.
18. To receive administrative information regarding changes in or termination of the patient management program.
19. The right to have personal health information (PHI) shared with the Patient Management Program only in accordance with state and federal law.
20. To the confidentiality and privacy of all information contained in the patient record and of Protected Health Information.
21. To receive pharmacy health and safety information to include consumer rights and responsibilities.
22. To identify the program's staff members, including their job title, and to speak the staff member's supervisor if requested.
23. To speak to a health professional.
24. To receive information on how to access support from consumer advocate groups.
25. Be informed of patient rights under state law to formulate an Advanced Directive, if applicable.



26. Be advised on agency's policies and procedures regarding the disclosure of clinical records.
27. Be informed of any financial benefits when referred to an organization.

**PATIENT RESPONSIBILITIES:**

1. To provide accurate and complete information regarding your past and present medical history and contact information and any changes.
2. To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments.
3. To participate in the development and updating of a plan of care.
4. To communicate whether you clearly comprehend the course of treatment and plan of care.
5. To comply with the plan of care and clinical instructions.
6. To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services.
7. To respect the rights of Pharmacy personnel.
8. To notify your Physician and the Pharmacy of any potential side effects and/or complications.
9. To notify the HTC Pharmacy via telephone when medication supply is running low so refill may be shipped to you promptly.
10. Patient agrees to request payment of authorized Medicare, Medicaid, or other private insurance benefits be paid directly to The University of Colorado Hemophilia Center Pharmacy for any services furnished by The University of Colorado Hemophilia Center Pharmacy.
11. Patient agrees to accept all financial responsibility for products furnished by The University of Colorado Hemophilia Center Pharmacy.
12. Patient understands that The University of Colorado Hemophilia Center Pharmacy retains the right to refuse delivery of service to any patient at any time.
13. Patient agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken.
14. To give accurate clinical and contact information and to notify the patient management program of changes to this information.
15. To notify their treating provider of their participation in the patient management program, if applicable.
16. To submit any forms that are necessary to participate in the program, to the extent required by law.
17. To maintain any equipment provided.

If you have questions, concerns or issues that require assistance, please call 1-866-724-7427. Complaints will be forwarded to management and you will receive a response within 5 business days.

When the patient is unable to make medical or other decisions, the family should be consulted for direction.

All staff members will understand and be able to discuss the Patient Bill of Rights and Responsibilities with the patient and caregiver(s). Each staff member will receive training during orientation and attend an annual in-service education class on the Patient Bill of Rights and Responsibilities



## HIPAA PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### OUR COMMITMENT TO YOUR PRIVACY

It is our duty to maintain the privacy and confidentiality of your protected health information (PHI). We will create records regarding your and the treatment and service we provide to you. We are required by law to maintain the privacy of your PHI, which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the Pharmacy.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from Vincent Fusaro at 1-866-767-4883.

### PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of *treatment, payment and health care operations*. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means providing services as ordered by your physician. Treatment also includes coordination and consultations with other health care providers relating to your care and referrals for health care from one health care provider to another. We may also disclose PHI to outside entities performing other services related to your treatment such as hospital, diagnostic laboratories, home health or hospice agencies, etc.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, prior approval, determinations of eligibility and coverage and other utilization review activities. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

Health care operations means the support functions of the Pharmacy, related to *treatment and payment*, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. We may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

### OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

To provide appointment reminders for treatment or medical care.

To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

To disclose to your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such disclosures.

We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

We will use or disclose PHI about you when required to do so by applicable law.

In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Pharmacy as required by applicable law.

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

### SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.

Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:



- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

**Health Oversight Activities.** We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

**Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises; or
- In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**Serious Threats.** As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

**Note:** HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

## OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

## YOUR RIGHTS

You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to the Privacy Officer.

You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.

You have the right to inspect and copy the PHI contained in our Pharmacy records, except:

- for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);
- for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
- for PHI involving laboratory tests when your access is restricted by law;
- if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you;
- if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
- for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and
- for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

You have the right to request an amendment to your PHI but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- is not part of your medical or billing records or other records used to make decisions about you;
- is not available for inspection as set forth above; or
- is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to Medical Record Custodian at our Pharmacy, along with a description of the reason for your request.

You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

- to carry out treatment, payment and health care operations as provided above;
- incidental to a use or disclosure otherwise permitted or required by applicable law;
- pursuant to your written authorization;
- to persons involved in your care or for other notification purposes as provided by law;
- for national security or intelligence purposes as provided by law;
- to correctional institutions or law enforcement officials as provided by law;
- as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our Pharmacy. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

#### COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Privacy Officer for The University of Colorado Hemophilia Center Pharmacy at 303-724-0168. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington D.C 20201.

#### CONTACT PERSON

If you have any questions or would like further information about this notice, please contact The University of Colorado Hemophilia Center Pharmacy Privacy Officer at 303-724-0168.



## GRIEVANCE / COMPLAINT REPORTING

We want you to be completely satisfied with the care we provide. If you have any issues with your medication, the services rendered, or any other issues related to your order, please contact us directly and speak to one of our staff members.

You may lodge a complaint or report a suspected error, without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call 303-724-0172 and speak to the Pharmacy Manager. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.

You may also make inquiries or complaints about this company by calling:

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**University of Colorado Hemophilia Governing Body (Paul Limberis- Chair)**

13199 East Montview Blvd Ste 100  
Aurora CO 80045  
Phone- 303-724-0172  
Email- [hemophilia@ucdenver.edu](mailto:hemophilia@ucdenver.edu)

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**The Colorado State Board of Pharmacy  
Department of Regulatory Affairs (DORA)**

Phone – 303-894-7800  
Fax – **303-894-2310**  
Email – [dora\\_pharmacy@state.co.us](mailto:dora_pharmacy@state.co.us)  
<http://www.colorado.gov/dora/pharmacy>

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**URAC**

1220 L Street, NW  
Suite 400  
Washington, D.C. 20005  
**Phone: (202) 216-9010**  
**Fax: (202) 216-9006**  
<http://webapps.urac.org/complaint/>

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**Office of Inspector General, Department of Health and Human Services**

HHS-Tips Hotline  
P.O. Box 23489  
Washington, D.C. 20026  
**Phone: (800) HHS-TIPS**  
**Phone: (800) 447-8477**

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**US Department of Labor OSHA**

Phone: (800) 321-OSHA(6742)  
[www.osha.gov](http://www.osha.gov)

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## **PATIENT MANAGEMENT PROGRAM**

- As a patient of our specialty pharmacy program, we monitor your medications and progress through a disease specific patient management program. This program is designed to provide benefits such as increasing adherence to drug therapies, managing side effects, and overall improvement of your health, when you are willing to follow the treatment plan determined by you, your doctor and your pharmacist. This service is provided to you at no cost, and your participation is voluntary. If you no longer wish to participate in our Patient Management Program, you may contact our team by phone to opt-out.

## **HOW TO REORDER FACTOR AND SUPPLIES**

- Call the pharmacy (303-724-0168 or 1-888-724-7427) seven days before you will run out of factor to place your order.
- The refill date may be limited by the insurance benefit plan, early refills or additional doses will require authorization from your insurance plan. We will assist you in obtaining any insurance authorizations.
- Always keep at least one MAJOR dose and two MINOR doses of factor on hand at all times\*
- Inhibitor patients should have a minimum of three days supply of Novoseven/Feiba on hand to treat an acute bleed\*
- The HTC pharmacy is open 8:30 am- 4:30 pm, Monday-Friday. Call anytime during business hours to obtain refill status. If calling outside of normal business hours, you can leave a message for the pharmacy team or have the on-call pharmacist paged for factor medication concerns. For medical emergencies call 911.

\* As recommended by the National Hemophilia Foundation's Medical and Scientific Committee (MASAC)

## **PRESCRIPTION TRANSFERS**

- If you feel that our pharmacy is unable to meet your needs, we can transfer your prescription to the appropriate pharmacy of your choice. Please call us.
- If our pharmacy can no longer service your medication, a pharmacist will transfer your prescription to another pharmacy. We will inform you of this transfer of care.

## **GENERIC SUBSTITUTIONS**

- All factor prescription orders will be filled ONLY with the prescribed factor, no substitutions will be made without the provider and patient's permission.
- Other medications dispensed by the HTC pharmacy, such as tablets, nasal sprays, creams and syrups, for these medications, brand name medication may be substituted by an equivalent generic medication when available.

### **ADVERSE DRUG REACTIONS/FACTOR ISSUES**

- Call the HTC pharmacy and request to speak with a pharmacist if you are having a non-life threatening drug reaction, you feel like your factor is not working, you are having trouble infusing or if the medication has been stored improperly.
- For life-threatening drug reactions call 911 immediately.

### **DELIVERY AND STORAGE OF YOUR MEDICATION**

- We deliver medication to your home or to an alternate location at no cost to you. We will also include other supplies, such as a sharps container, as requested. We coordinate all refills to make sure that you, or an adult family member, is available to receive the shipment.
- If your medication requires refrigeration, we will ship it in special packaging that will maintain the appropriate temperature throughout the shipping process. Once you receive the package, take the medication out of the box and place it in the refrigerator.
- If the package looks damaged or is not in the correct temperature range (the Timestrip device is displaying blue), please call us.
- If your delivery is going to be delayed a member of the pharmacy team will contact you and provide you with a tracking number and ETA for your package.

### **MEDICATION SAFETY**

- In order for your medications to remain effective they need to be stored properly.
- Always store drugs out of children's reach.
- Always keep medicines in their original container.
- Refer to the manufacturer's packing information.
- Check the expiration date each time you take a drug.
- Replace any medications that are out of date.
- Never use a medication that has changed color, texture, or odor, even if it has not expired. Throw away capsules or tablets that stick together, are harder or softer than normal, or are cracked or chipped.
- Ask your pharmacist about any specific storage instructions.

For more information about medication storage refer to the [National Institutes of Health article](#).

### **PROPER DISPOSAL OF UNUSED MEDICATIONS**

- For instructions on how to properly dispose of unused medications, check with your local waste collection service. You can also check the following websites for additional information:

<http://www.fda.gov/forconsumers/consumerupdates/ucm101653.htm>

<http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm>



### **PROPER DISPOSAL OF SHARPS**

- Place all needles, syringes, and other sharp objects into a sharps container. This will be provided by the Pharmacy if you are prescribed an injectable medication.

### **DRUG RECALLS and DRUG SHORTAGES**

- If your medication is recalled, the HTC Pharmacy will contact you with further instructions, as directed by the FDA or drug manufacturer.
- The HTC Pharmacy will make every effort to provide you with uninterrupted service. If a factor product becomes unavailable, we will work with other HTC's, wholesalers and the manufacturer to minimize any issues in obtaining your factor medications.

### **CONSUMER ADVOCACY SUPPORT & HEMOPHILIA RESOURCES INFORMATION**

- ❖ Colorado Chapter of NHF: [www.cohemo.org](http://www.cohemo.org)
  - Information on summer camp program      °Short Term Travel Assistance
  - Short term financial assistance              °Educational programs and information
- ❖ National Hemophilia Foundation: [www.hemophilia.org](http://www.hemophilia.org)
  - [MASAC recommendations](#)
- ❖ World Federation of Hemophilia: [www.wfh.org](http://www.wfh.org)
- ❖ University of Colorado Hemophilia Center: [www.medshool.ucdenver.edu/htc](http://www.medshool.ucdenver.edu/htc)
  - Information on making clinic appointment
  - On-going clinical trials
  - Contacting providers
  - Factor information
  - Hours of operation and scheduled closures

### **TRAVEL TIPS**

- Always wear medical identification (ie MedAlert necklace or bracelet) and carry a copy of your bleeding alert card
- Always keep your factor and supplies with you in your carry-on bag
- Call HTC and request a travel letter
- Know where the closest HTC is located: [www.cdc.gov/ncbddd/hemophilia/HTC.html](http://www.cdc.gov/ncbddd/hemophilia/HTC.html)
- Make sure your hotel room has a refrigerator for factor
- Make arrangements with your pharmacy to have factor shipped to your destination (within the USA)

### **EMERGENCY DISASTER INFORMATION**

- In the event of a disaster in your area, please contact the HTC Pharmacy to instruct us on how to deliver your medication. This will ensure your therapy is not interrupted.

- In the event that the HTC pharmacy has a disaster that affects the pharmacy from being able to dispense and/or deliver your medication, a member of the pharmacy staff will contact you immediately with instructions on how to obtain your factor, so that there is no disruption in your therapy.



## PATIENT AUTHORIZATION AND PLAN OF SERVICE

**Insurance payment authorization:** I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to The University of Colorado Hemophilia Center Pharmacy for pharmaceuticals / supplies that were furnished to me for which they bill you on my behalf.

**Release of insurance information:** I request my medical insurance plan(s) to release to the above named company, any and all information which will assist in processing my claims for medical supplies and/or equipment that I am receiving from the above named company even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or the above named company any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for medications, services and supplies that I have received, rather than directly to the above named company, I agree to endorse those checks and send them immediately to the above named company.

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under The University of Colorado Hemophilia Center Pharmacy financial hardship program.

\_\_\_\_ (Initials) I acknowledge that I have been advised of my financial obligations to The University of Colorado Hemophilia Center Pharmacy including copays, deductibles and any anticipated denials for products furnished by The University of Colorado Hemophilia Center Pharmacy.

\_\_\_\_ (Initials) I acknowledge that I have received a copy of the HIPAA PRIVACY NOTICE

I hereby agree that The University of Colorado Hemophilia Center Pharmacy or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

I have reviewed and understand the information above. I have been instructed on and understand the use of the products provided. I have received the products ordered. I have received a copy of a patient handout that contains a welcome letter, patient rights and responsibilities, privacy standards, emergency planning, making decisions about your health care, grievance/complaint information and drug disposal techniques. I have received the product manual/instructions, warranty information, and instructions to follow up with The University of Colorado Hemophilia Center Pharmacy.

I understand that prescribed medications cannot be re-dispensed. Therefore, these items cannot be returned for credit.

I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

**Identified needs/problems:** The patient may be unfamiliar with use of the medications and product(s) provided. Expected outcomes: The patient will be provided the medications and product(s) to comply with the physician's prescription. The patient will use the medications and product(s) as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT NAME: \_\_\_\_\_

PATIENT OR RESPONSIBLE PARTY (IF UNDER 18 YEARS OF AGE)

PRINT NAME: \_\_\_\_\_

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

IF BENEFICIARY IS UNABLE TO SIGN: \_\_\_\_\_

WITNESS SIGNATURE / RELATIONSHIP: \_\_\_\_\_

REASON PATIENT UNABLE TO SIGN: \_\_\_\_\_

Please return the Patient Authorization and Plan of Service Form to The University of Colorado Hemophilia Center Pharmacy in the envelope provided. Thank you for choosing The University of Colorado Hemophilia Center Pharmacy.







## AUTHORIZATION FOR THE RELEASE OF PERSONAL HEALTH INFORMATION

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Type of personal health information (PHI) to be released:

- ☐ Medication dose and refill information
- ☐ Insurance information
- ☐ Medical information (ex. Bleeds, pain, diagnosis, other)

Authorization release PHI to:

- ☐ Mother ☐ Father ☐ Sister/brother
- ☐ Spouse/domestic partner ☐ Son/daughter ☐ Other: \_\_\_\_\_

I give the HTC Pharmacy permission to leave messages on voice mail pertaining to:

- ☐ Medication refills ☐ Drug recalls ☐ Clinic appointment reminder ☐ Do not leave messages

For the following purposes:

- ☐ Medication/factor refills ☐ Pharmacy Medication Program ☐ Billing/Insurance issues

-I understand that I may revoke this Authorization at any time, revocation of this request should be made know to the University of Colorado Hemophilia Pharmacy verbally or in writing. I understand that information used or disclosed pursuant this Authorization may be subject to re-disclosure by the recipient and my no longer be protected by applicable privacy law. I further understand that the HTC pharmacy and its employees are released from legal responsibility or liability for the use and disclosure of the above released information to the extent indicated and authorized.

**I HAVE READ AND UNDERSTAND THIS INFORMATION; I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

If patient if unable to sign, secure consent of Legal Representative and indicate reason below:

- ☐ Minor ☐ Incompetent

\_\_\_\_\_  
Signature of Legal Representative and Relationship to Patient







# HTC Pharmacy Satisfaction Survey

The HTC Pharmacy welcomes feedback from those we serve to see how well we are meeting your needs. We are providing a survey to our HTC Pharmacy clients to improve services. This survey is anonymous. We welcome your feedback on areas we need improvement, as well as comments on things we are doing right. You can fill in the questionnaire below and mail it to us in the enclosed envelope, or simply go online and fill it out at: <http://j.mp/2P6HR2k>

Thank you in advance for your time and for using the HTC Pharmacy.

I am a: (select one)    ☐ Patient    ☐ Patient Caregiver

Please respond to each question with the most accurate ranking possible between 1 (poor) and 5 (excellent):

1. How would you rate the professionalism of the HTC pharmacy staff?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
2. How would you rate the accuracy of the medications and/or supplies the HTC Pharmacy provided or mailed to you?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
3. How would you rate the materials and instructions that were included in your HTC Pharmacy order (such as how to tell if factor was kept cool, or how to contact us etc.)?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
4. How would you rate the ease of getting in contact with the HTC Pharmacy via telephone?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
5. How would you rate the ease of getting answers to your questions, follow-up, or concerns you may have from the HTC Pharmacy staff?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
6. How would you rate the timeliness of scheduling & receiving your order from the HTC Pharmacy?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
7. How would you rate the ease of contacting the HTC Pharmacists after hours?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
8. How would you rate how clearly your financial responsibilities were explained to you by the HTC Pharmacy staff?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
9. How would you rate your overall experience with the HTC Pharmacy?  
☐ 1 (very poor)    ☐ 2 (poor)    ☐ 3 (good)    ☐ 4 (very good)    ☐ 5 (excellent)    ☐ N/A
10. Would you recommend the HTC Pharmacy to a friend or family member who could use our services?  
☐ 1 (never)    ☐ 2 (not likely)    ☐ 3 (maybe)    ☐ 4 (likely)    ☐ 5 (very likely)    ☐ N/A

If you have any additional comments or complaints about the HTC Pharmacy, please include them below:

## **Encuesta de satisfacción de la farmacia en el centro para la hemofilia y trombosis** ***HTC Pharmacy Satisfaction Survey***

En la farmacia del *HTC* (por sus siglas en inglés) recibimos gustosamente la retroalimentación de aquellos a quienes servimos a fin de saber qué tan bien satisfacemos sus necesidades y para mejorar los servicios, concedemos una encuesta a nuestros clientes de la farmacia en el *HTC*. Esta encuesta es anónima. Agradecemos su retroalimentación en los ámbitos donde necesitamos mejorar así como comentarios respecto a lo que hacemos correctamente. Usted puede contestar la siguiente encuesta y enviárnosla por correo en el sobre adjunto o simplemente entrar a internet y contestarla en: <http://j.mp/2P6HR2k>

De antemano, agradecemos su tiempo y uso de la farmacia en el *HTC*.

**Yo soy: (seleccione uno)** ☐ paciente ☐ tutor del paciente

Por favor, conteste cada pregunta con la calificación más exacta posible entre 1 (lo más peor) y 5 (excelente):

- 1. ¿Cómo calificaría el profesionalismo del personal de la farmacia del HTC?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 2. ¿Cómo calificaría la exactitud de los medicamentos y/o los suministros que le surtió o envió por correo la farmacia del HTC?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 3. ¿Cómo calificaría los materiales e instrucciones incluidas en su orden de la farmacia del HTC (tales como indicarle si algún factor debe mantenerse en refrigeración o cómo contactarnos, etc.)?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 4. ¿Cómo calificaría la facilidad para ponerse en contacto con la farmacia del HTC vía telefónica?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 5. ¿Cómo calificaría la facilidad para obtener respuestas a sus preguntas, seguimiento o inquietudes que usted podría tener para el personal de la farmacia del HTC?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 6. ¿Cómo calificaría la puntualidad de la programación y recibo de su orden de la farmacia del HTC?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 7. ¿Cómo calificaría la facilidad para comunicarse con los farmacéuticos de HTC fuera de horas hábiles?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 8. ¿Cómo calificaría qué tan claramente le explicó el personal de la farmacia del HTC sus responsabilidades financieras?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 9. ¿Cómo calificaría usted su experiencia en general con la farmacia del HTC?**  
☐ 1 (lo más peor)    ☐ 2 (peor)    ☐ 3 (bien)    ☐ 4 (muy bien)    ☐ 5 (excelente)    ☐ N/A (no se aplica)
- 10. ¿Recomendaría la farmacia del HTC a un amigo o pariente quien podrían usar nuestros servicios?**  
☐ 1 (nunca)    ☐ 2 (menos posible)    ☐ 3 (posiblemente)    ☐ 4 (más posible)    ☐ 5 (lo más posible)    ☐ N/A (no se aplica)

Por favor, si tiene cualquier comentario adicional o quejas acerca de la farmacia en el *HTC*, inclúyalas a continuación: