



## HEALTH AND HUMAN SERVICES POLICY

**Department:** Health Services-Pharmacy

**Policy Number:** 1808

**Policy Title:** Prescription Distribution

**Policy Attachment:** Prescription Delivery Form

**Revision History:** 1984, 7/01, 7/12, 2/13, 9/2020

**Revised by/Date:** 11/2022 Jesse Godding

**Commissioner Initials:** *JG* **Director Initials:** *JM*

**Approved by:** *Jan Manary*

**Date:** 12.29.2022

Jan Manary, Executive Director of Health Services

**POLICY:** The Ne-Ia-Shing Clinic Pharmacy will ensure that prescriptions are distributed to patients in a manner which promotes patient safety and quality patient care.

### **AUTHORITY:**

USPS Publication 52 Section 453 Controlled Substances and Drugs  
DEA Pharmacist Manual  
Minnesota Statue 6800.3000 Prescriptions and Distribution of Drugs

### **POLICY DETAILS:**

#### **1. Personnel Authorized to Dispense Prescriptions**

The following personnel may dispense completed prescriptions to patients:

Pharmacists  
Pharmacy Technicians  
Providers  
Nurses

#### **2. Methods of Dispensing Medications**

##### **A. Patient Pickup**

Completed prescriptions will be available for in person pickup at the Ne-Ia-Shing Clinic Pharmacy. Patients may also choose to have their medications sent to the ALU, Hinckley ALU, East Lake Clinic, or Lake Lena Clinic via pharmacy courier for in person pickup. Once medications have been delivered to these sites, they must be picked up on site by the patient. They may not be delivered to the patient's residence by staff.

Pick up of controlled medications will not be available at Hinckley ALU.

Patients must pick up their own medications and parents/guardians must pick up for any minors in their care. The patient or guardian may authorize another individual to pick up medications in their stead as long as the pharmacy is notified ahead of time by the patient/guardian.

##### **B. Mailing Directly to Patients**

Ne-Ia-Shing pharmacy will mail prescriptions directly to qualified patients upon patient request.



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Patients may qualify for direct mail if they:

- Are receiving regular visits from a public health nurse
- Are an elder
- Have a documented reason why picking up in person is unfeasible

Medications may also be mailed to a patient who typically picks up at an outer district location if that location will be unable to accept medication delivery for at least 3 business days in a row.

Prescriptions will only be mailed to a patient's home address. We will not mail to PO boxes. It is the patient's responsibility to ensure Ne-Ia-Shing Clinic Pharmacy has an updated address on file.

All prescriptions mailed will require a signature upon receipt. Prescriptions will not be left in a mailbox or outside a patient's residence.

Certain medications will not be sent through the mail. This may be due to risk of damage to the medication or other factors. These include but are not limited to:

- Medications which require refrigeration
- Medication which requires protection from freezing
- Medications which are sensitive to shaking or bumping
- Medications which are fragile
- Meal supplement drinks or other bulk liquids

The pharmacist on site will have the final say on whether or not it is safe and appropriate to mail a medication.

Any special circumstances regarding execution of this policy will be reviewed on a case-by-case basis by the pharmacy managing director or designee.

|                                  |                                                                                                |
|----------------------------------|------------------------------------------------------------------------------------------------|
| <b>Replaces Policy Number</b>    |                                                                                                |
| <b>Compliance - Posting Date</b> | 12/29/2022  |
| <b>Next Review - Due Date</b>    | 12/2025                                                                                        |

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## Prescription Delivery Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

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

Prescription Numbers:

|       |       |       |       |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Name and Signature of employee delivering medications:

\_\_\_\_\_ Date: \_\_\_\_\_

By signing below, I acknowledge that I have received the prescriptions listed on this form

Name and Signature of patient receiving medications

\_\_\_\_\_ Date: \_\_\_\_\_