TUBERCULOSIS MEDICATION RETURN FORM

INSTRUCTIONS:

Unused, discontinued or returned medications (from the client) need to reviewed and documented for return to the Drug Room every thirty (30) days.

Please provide detailed information in order for the Drug Room to properly process the items for return credit or ability to recycle them for future drug orders. Please do not deface packaging prior to return as it may affect its ability to receive credit. Timely returns can help prevent accidental administration to an incorrect client or improper dosing during therapy modifications.

"Leftover or unused medications" can be an area of concern regarding one of the requirements of 340B compliance in preventing drug diversion. Drug diversion in the program is defined as a 340B drug being provided to an individual who is not an eligible outpatient of that entity and/or dispensed in an area of a larger facility that is not eligible (eg, an inpatient service or a non-covered clinic).

Examples of drug diversion include:

- Dispensing 340B drugs at ineligible sites.
- Not monitoring and correcting inventory.
- Dispensing 340B drugs written by ineligible providers.

Do not administer or dispense unused medication for another client as it is specifically labeled for an intended person, doing so maybe considered an act of diversion and inappropriate practice of care. Violations could affect the State's drug purchasing contract and your professional license to practice based upon your professional regulations.

TUBERCULOSIS MEDICATION RETURN FORM

TB Form Field Requirements:

Please provide the following information:

- Column A Patient Name
- Column B Select Correct Drug **or** type in drug if not on the dropdown
- Column C Quantity Returning to Drug Room (Actual Number of TABS/CAPS)
- Column D Select Appropriate Reason from below (1-7):
  1 – Expired **2 –** Overstock **3 –** Change in Therapy/Discontinued **4 –** Lost to Follow Up
  5 – Drug Recall **6 –** Client declined therapy **7 –** Other
- Column E If "**7 – Other**" please give brief detail in "Other/Comments"
- Column F Check **YES** or **NO** (Field Name "**QUALITY ASSURANCE**")
  - Please check the appropriate box regarding that Medications have been stored properly at Controlled Room Temperature **and** remained at the Public Health Facility under secure conditions
  - Medications that have left the security of the originating facility and that get returned should be marked a "NO" under the quality assurance check box

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Name of Facility: Select from dropdown **or** type in facility name

Completed by: Type in your name

Contact Phone #: Enter a contact phone number

Date Sent: Enter in date

Return the completed form with medications to:

ALASKA DHSS / DPH – TB QUALITY CONTROL
9210 VANGUARD DR SUITE 102 – A
ANCHORAGE, AK 99507

Any questions or concerns please contact the Epidemiology Drug Room 907-341-2207 or 907-341-2209

TB MEDICATION RETURN FORM

	A	B	C	D	E	F	F
	Patient Name	Drug Name	Qty	Reason For Return	Other / Comments	Quality Assurance	For Drug Room Use
1						YES ☐ NO ☐	
2						YES ☐ NO ☐	
3						YES ☐ NO ☐	
4						YES ☐ NO ☐	
5						YES ☐ NO ☐	
6						YES ☐ NO ☐	
7						YES ☐ NO ☐	
8						YES ☐ NO ☐	
9						YES ☐ NO ☐	
10						YES ☐ NO ☐	
11						YES ☐ NO ☐	
12						YES ☐ NO ☐	

Name of Facility: * Itinerant Nursing

Completed by:

Contact Phone #:

Date Sent:

Return the completed form with medications to:

ALASKA DHSS / DPH-TB QUALITY CONTROL
9210 VANGUARD DR SUITE 102 -A
ANCHORAGE, AK 99507

Please review items for return every 30 days

INCLUDE COMPLETED FORM WITH THE ITEMS BEING RETURNED TO THE DRUG ROOM. RETAIN A COPY FOR YOUR RECORDS FOR 2 YEARS.
ANY QUESTIONS FILLING OUT THIS FORM, PLEASE CONTACT THE DRUG ROOM AT 341-2207 or 341-2209

Rev Nov 2016