Medication Therapy Management/ Comprehensive Medication Review Adult/Child Assessment

Patient name:
Patient DOB:
Patient member ID#:
Provider name:
Provider practice name:
Provider NPI#:

1. Who is being interviewed?
   - ○ Patient
   - ○ Parent
   - ○ Spouse/significant other
   - ○ Legal guardian
   - ○ Caregiver
   - ○ Other:

2. List any medication allergies.

3. List ALL of the patient's medications, including prescription, over-the-counter (OTC) and/or herbs/supplements.

4. Did you review with the patient all their current prescription medications?
   - ○ No
   - ○ Yes

5. Did you review with the patient all their current OTC medications and/or herbs/supplements?
   - ○ No
   - ○ Yes

6. Have you identified any medication therapy issues, such as drug interactions or duplicate therapies?
   - ○ No
   - ○ Yes. Please explain and describe the interventions made for these medication therapy issues.

7. Is the patient experiencing any side effects from their medications?
   - ○ No
   - ○ Yes. Please explain and describe the interventions made for managing patient side effects.

8. Has the patient ever had any problems in taking their medications exactly as prescribed?
   - ○ No
   - ○ Yes. Please explain and describe solutions provided to the patient to overcome the problems in taking their medications as prescribed.

9. Over the last two weeks, which of the following would best describe how frequently the patient missed taking any of their medications as prescribed?
   - ○ None/never
   - ○ Rarely — once or twice over the last two weeks
   - ○ Occasionally/sometimes — miss taking every now and then, but not on a regular basis
   - ○ Frequently/often — miss on a regular basis, such as 3 – 4 times per week or more
   - ○ Most/all the time — miss taking more than half the time

10. Is the member having any issues in getting their prescriptions filled?
   - ○ No
   - ○ Yes. Please explain and describe the interventions made to help the patient get their prescriptions filled.

11. Has the patient had any of the following vaccinations?
   - ☐ COVID-19
   - ☐ Hepatitis A
   - ☐ Hepatitis B
   - ☐ Human papillomavirus (HPV)
   - ☐ Influenza (within the last year)
   - ☐ Measles, mumps, rubella (MMR)
   - ☐ Meningococcal
   - ☐ Pneumococcal (within the last 5 years)
   - ☐ Tetanus, diphtheria, pertussis (Td/Tdap) (within the last 10 years)
   - ☐ Varicella
   - ☐ Zoster
   - ☐ Other:

12. Has the patient received the appropriate vaccinations based on their age, birth sex, and chronic condition(s)?
   - ○ Yes
   - ○ No. Please list the vaccinations the member is eligible for and has not received:

   Describe the plan for the member to receive all eligible vaccinations.

13. Have you identified any other barriers to care related to the patient's medication regimen?
   - ○ No
   - ○ Yes, please explain and describe the interventions made to help the patient overcome any barriers to care.

Medication Action Plan

AmeriHealth Caritas
New Hampshire

Member name:	Date of birth:

This medication action plan was prepared for you after we talked. This will help summarize our discussion.

- Read the "What we talked about" section.
- Take the steps listed in "What I need to do" section.
- Fill in the "What I did and when I did it" section.
- Fill in the "My follow-up plan" section.
- Have this action plan ready with you when you go to your next visit.
- Ask your doctor or other health care providers about any questions or concerns you may have.

Date prepared:

What we talked about:	
What I need to do:	**What I did and when I did it:**
What we talked about:	
What I need to do:	**What I did and when I did it:**

My follow-up plan (add notes about next steps):

Questions I want to ask (include topics about medication or therapy):

Medication List

AmeriHealth Caritas
New Hampshire

Member name:	Date of birth:

Your medication list was made after we talked.

- Use the blank rows to add new medications you may start in the future.
- Cross out medications you no longer use and add the reason why you stopped.
- Ask your doctor or health care providers to update the list every visit.
- If you go to the hospital, take this list.

Date prepared:

Allergies or side effects:

Medication:	
How I use it:	
Why I am on this medication:	
Doctor's name:	
Date I started on the medication:	Date I stopped using it:
Why I stopped using it:	

Medication:	
How I use it:	
Why I am on this medication:	
Doctor's name:	
Date I started on the medication:	Date I stopped using it:
Why I stopped using it:	

Medication:	
How I use it:	
Why I am on this medication:	
Doctor's name:	
Date I started on the medication:	Date I stopped using it:
Why I stopped using it:	

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