standing orders with the prescriber. These standing orders need to be reviewed and updated regularly, usually on an annual basis. Like all other orders, standing orders are not exempt from a timely signature and must be signed by the prescriber as soon as possible.

Stop Orders

Automatic stop orders are given for a limited time only. A common example is an order for Schedule II and III drugs after an injury or surgical procedure. Most likely, the patient will experience some level of pain for a short time following the injury or surgery, and the physician therefore orders a Schedule II narcotic analgesic to be taken every 4 hours as needed. Because this prescription cannot be refilled unless the prescriber renews it, the patient is less likely to become addicted to the medication. Another example is an antibiotic to be taken twice a day for 10 days. The order stops after 10 days and is not refilled unless the prescriber renews it. To "d/c" an order is to discontinue it.

Regardless of the order, the prescription must be clear. Patients can suffer serious consequences or possibly die if a pharmacist misinterprets a prescription and gives the wrong medication or the wrong dose. Your role is to be the safety check before the prescription is sent to the pharmacist, to make sure the information is accurate and legible.

CRITICAL THINKING

You review a prescription and find that you cannot determine whether the medication is Trileptal (an antiseizure medication) or Tylenol 3 (a narcotic pain reliever). What would the difference mean to the patient if the wrong drug were given? What should you do in this situation?

PARTS OF A PRESCRIPTION

The prescription is a written record of the prescriber's order. In addition to physicians, nurse practitioners and physician assistants are allowed to prescribe medications. Prescription privileges differ from state to state. Research and learn who can prescribe medications in your state. Be sure the person ordering the medication is lawfully allowed to do so. On every prescription pad, the prescriber is identified by name and, if he or she is licensed to prescribe scheduled drugs, the prescriber's Drug Enforcement Administration (DEA) number. Only the patient whose name is on the prescription should take the medication.

Drugs are ordered in facilities such as hospitals, outpatient surgery centers, and prescribers' offices. Because you will probably have the most contact with prescriptions in a prescriber's office, that setting is the main focus of this discussion.

Every prescription must include two types of information, administrative information and specific information relating to the dispensing of the medication. The administrative information for controlled dangerous substances (CDS) must include the name, address, telephone number, and DEA number of the prescriber; the name and address of the patient; and the date of the order. For non-CDS prescriptions, it is not required by law to obtain either the patient's or the prescriber's address. The following list provides details for some of these parts:

- Date. Including the date of the order is important for filing insurance claims and for linking the drug therapy with the office visit. The date of the order should match the date of the office visit, even though patients may not fill the prescription for up to 1 month after the visit because they may receive free samples at the office or emergency department. Prescriptions should never be postdated.
- Physician's name, contact information, and DEA number. Large medical groups may use one prescription form with all the legal prescribers listed, or they may have separate prescription forms for each prescriber. All prescribers licensed to prescribe scheduled drugs must have their DEA numbers preprinted on the prescription form.