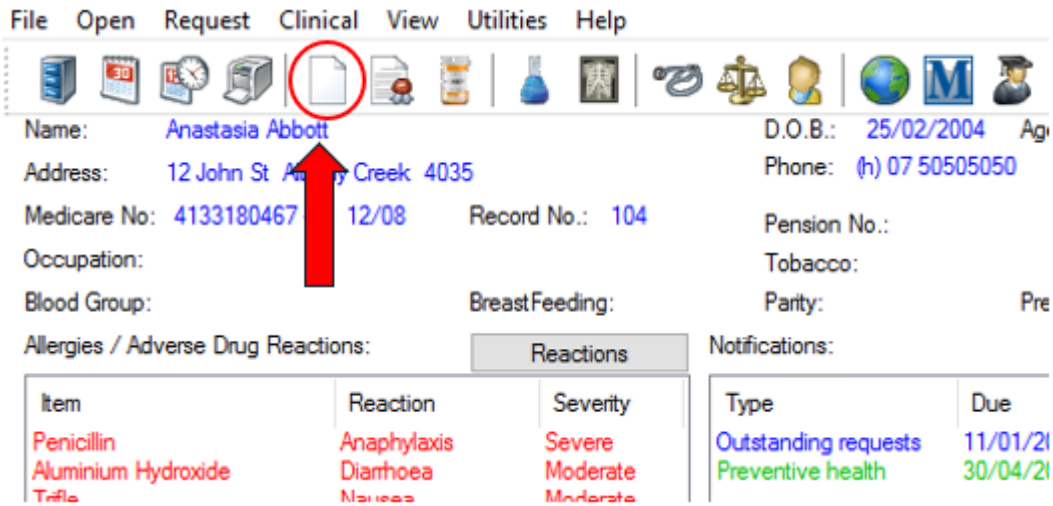
Creating a Medication Management Plan

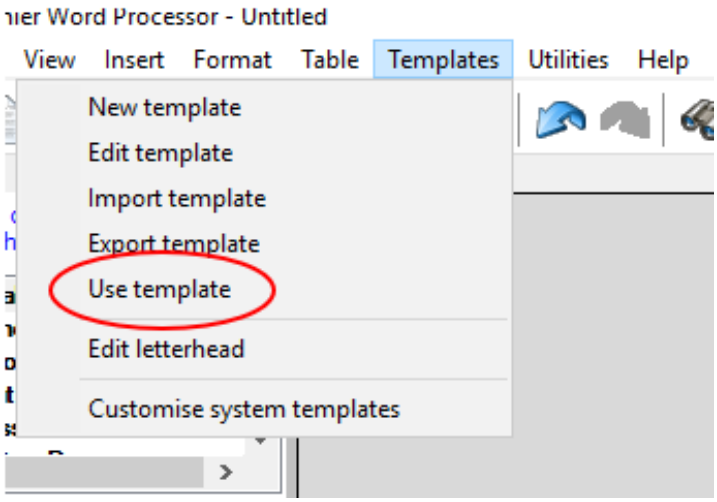
Best Practice

Claim Medicare Item 900 after developing a written **Medication Management Plan (MMP)** in accordance with MBS requirements. This should follow a discussion with the patient upon receipt of HMR/DMMR report.

1. Open the **Patient Clinical File**.
2. Open **Letter Writer** by clicking on the Letter Writer Icon.



3. Select **Templates** from the top drop-down menu and select **Use Template.**



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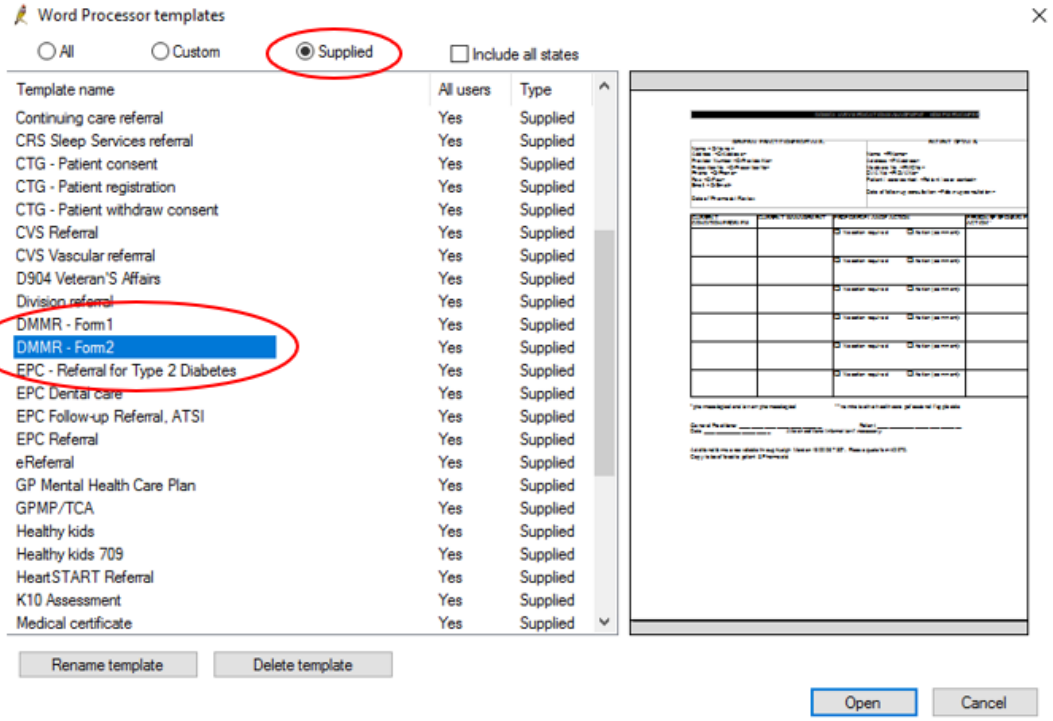
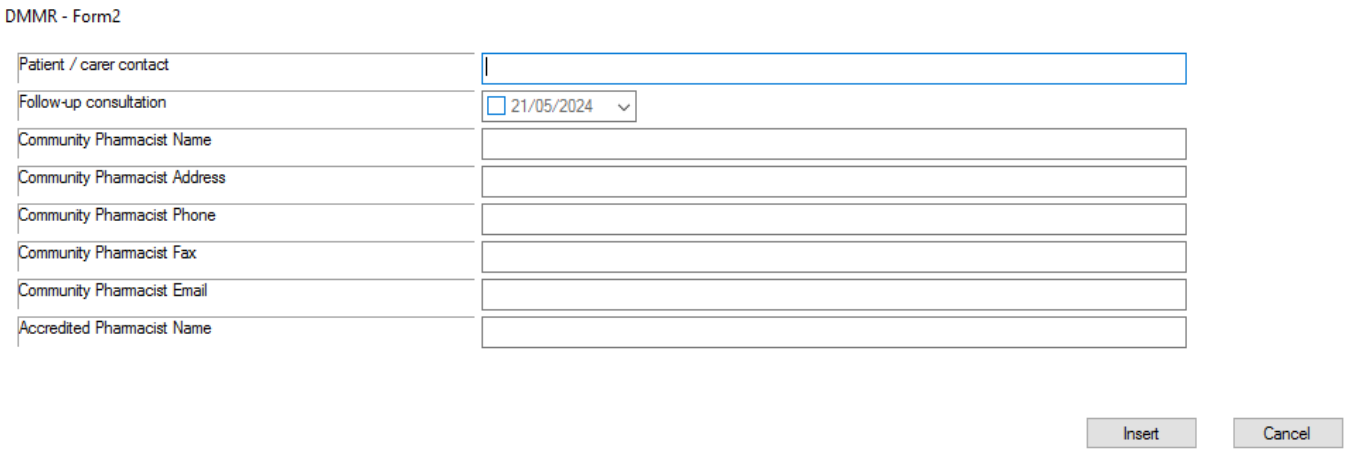
120 Chalk Street, Lutwyche QLD 4030
PO Box 845 Lutwyche QLD 4030
t 07 3630 7300

4. Select **Supplied** template tab.
5. Double click supplied **DMMR – Form2.**

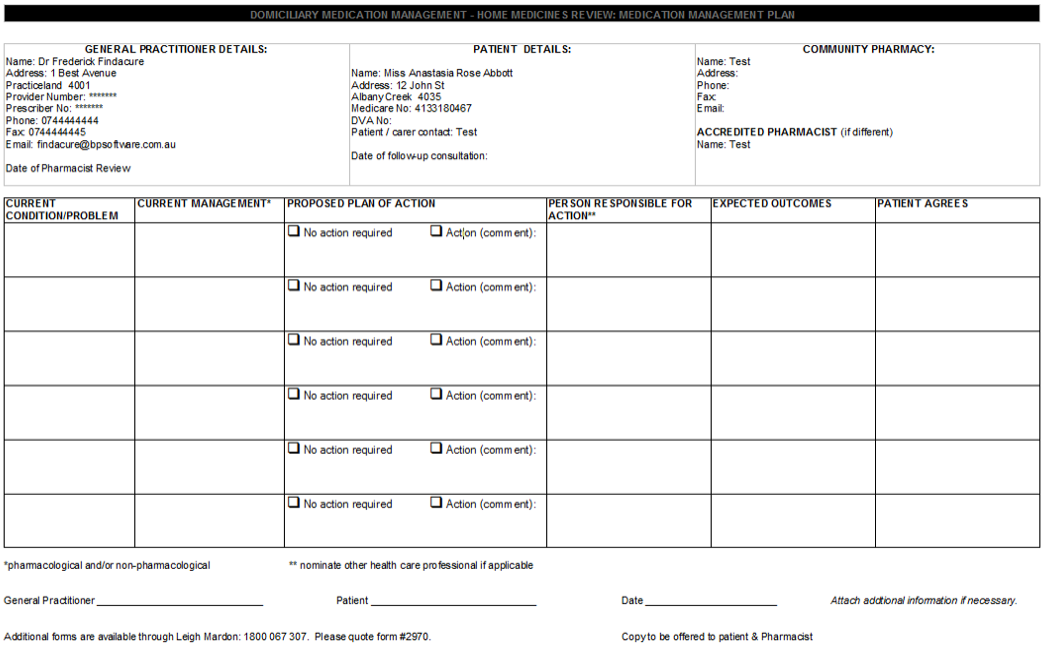


6. Complete relevant fields.
7. Include Credentialed (Accredited) Pharmacist name if different to Community Pharmacist name.
8. Select **insert.**



9. Complete the table ensuring all fields are filled and patient agrees to proposed plan of action.

Please note: To manually check a box, **backspace the box and press 'X' on the keyboard**. This will add a check box symbol.



DOMICILIARY MEDICATION MANAGEMENT – HOME MEDICINES REVIEW: MEDICATION MANAGEMENT PLAN

GENERAL PRACTITIONER DETAILS:	PATIENT DETAILS:	COMMUNITY PHARMACY:
Name: Dr Frederick Findacure Address: 1 Best Avenue Practiceland 4001 Provider Number: ******* Prescriber No: ******* Phone: 0744444444 Fax: 0744444445 Email: findacure@bpsoftware.com.au Date of Pharmacist Review	Name: Miss Anastasia Rose Abbott Address: 12 John St Albany Creek 4035 Medicare No: 4133180467 DVA No: Patient / carer contact: Test Date of follow-up consultation:	Name: Test Address: Phone: Fax: Email: **ACCREDITED PHARMACIST** (if different) Name: Test

CURRENT CONDITION/PROBLEM	CURRENT MANAGEMENT*	PROPOSED PLAN OF ACTION	PERSON RESPONSIBLE FOR ACTION**	EXPECTED OUTCOMES	PATIENT AGREES
		❑ No action required ❑ Action (comment):			
		❑ No action required ❑ Action (comment):			
		❑ No action required ❑ Action (comment):			
		❑ No action required ❑ Action (comment):			
		❑ No action required ❑ Action (comment):			
		❑ No action required ❑ Action (comment):			

*pharmacological and/or non-pharmacological ** nominate other health care professional if applicable

General Practitioner _____ Patient _____ Date _____ *Attach additional information if necessary.*

Additional forms are available through Leigh Mardon: 1800 067 307. Please quote form #2970. Copy to be offered to patient & Pharmacist

10. Attach additional information as necessary.
11. Print, date, both parties sign completed documentation.
12. Offer a copy of the medication management plan to the patient.
13. Send a copy of the medication management plan to the Credentialed Pharmacist and/or Community Pharmacy and other relevant health professionals by chosen secure messaging method.
14. Claim MBS Item 900.