

## 2. “Referral prescriptions” (e.g., those written by specialists)

The term “referral prescription” refers to a prescription written for an eligible FQHC patient (as defined under the 3-part test described in [Section 7.A.2](#)) that is written by a provider who is not directly employed by or under contract with the FQHC. For example, if the FQHC provider refers a patient to a specialist outside of the FQHC, and the specialist writes the patient a prescription, that prescription is called a “referral prescription.” The following question and answer from the Apexus website addresses patient referral prescriptions.

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**Q:** If we refer a patient to an outside clinic, can we fill their prescriptions from our 340B clinic?

**A:** A covered entity may refer an individual for consultation to an outside clinic not registered for the 340B Program and consider that patient 340B eligible only if the individual receives health care from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity (61 Fed. Reg. 55156 (October 24, 1996)). If the covered entity can document that it retained responsibility for the health care services provided to the referred individual, then that individual may be eligible to receive 340B drugs from the covered entity. How a covered entity counts referrals under the 340B Program should be addressed in their written policies and procedures.

The following points of this response merit close attention:

- Responsibility for the care that generated the referral prescription must remain with the FQHC, and
- The FQHC’s written policies and procedures for 340B should address how referrals are managed.

Thus, when using 340B drugs to fill referral prescriptions for its patients, the FQHC must:

- Be able to provide documentation of:
  - the referral to the specialist,
  - a summary of the referral visit, including prescriptions ordered by the referring physician – or evidence of its unsuccessful efforts to obtain this summary; and
  - the health center PCP’s continued responsibility for the care of the patients.
- Ensure that its 340B Policy and Procedures address the health center’s established eligibility criteria for referral prescriptions and how the Health Center documents its responsibility for care provided in a referral situation.

*An FQHC must retain – and document — responsibility for the care provided in order to fill a referral prescription for one of its patients.*

### 3. FQHC providers should not re-write prescriptions from other providers UPDATED

Health centers are **strongly advised against** having their providers rewrite prescriptions that were written by non-FQHC providers (e.g., specialists) for FQHC patients. This practice raises significant liability concerns. Health centers should consider having an official policy on this issue, in order to demonstrate that your health center has considered this issue and made an official determination of your position.

#### **Peer Perspective**

*“The FQHC should ensure that its P&P Manual outlines specific steps for documenting the referral in the Electronic Health Record. The In-House Pharmacy must be able to document the referral in the chart and then note on the prescription that the referral documentation is available. It should be able to supply documentation on ED prescriptions and also Hospital Discharge prescriptions.”*

### 4. How long is a referral to a specialist considered “active”?



As with the previous question, there is no specific guidance about how long a referral to a specialist considered is “active,” and therefore, that specialist prescriptions resulting from the referral can be filled with 340B drugs. Therefore, each health center should develop a policy that is consistent with its circumstances and the needs of its population.

When developing this policy, there are two parts to consider:

1. **How long do patients have to act on the referral (aka see the specialist)?** While there are no requirements in this area, many health centers have established a six-month window, as anything shorter might not accommodate scheduling barriers. If a patient does not see a specialist within 6 months of receiving the referral, a new referral is required if the resulting prescriptions are to be filled with 340B drugs.
2. Once the patient has the referral visit and a specialist prescription is deemed to be eligible based on the health center’s policy, how long does that prescription and its subsequent refills and renewals remain eligible? Again, there are no requirements in this area. However, a health center with a strong 340B compliance program recently provided the following input:

“Given the counsel of our auditing firm, our health center is adopting the position that as long as the health center PCP remains responsible for care and the specialty care is provided under that oversight, and the patient meets the definition of active, there is no need for repeat referrals or a schedule of required visits to the specialist (as this could be a financial and demographic burden for our patients). We have agreed however, that specialist prescription refills should be on an audit schedule to ensure the PCP is documenting knowledge of the continued specialty care and those meds.”