My name is Karen Gleason, and I am a licensed pharmacist in the state of Connecticut. I am providing written testimony on behalf of myself in support of **RB 895 An Act Concerning Changes to Various Pharmacy Statutes.**

I work under a collaborative drug therapy management (CDTM) protocol at an Anticoagulation Service where I manage the therapy of patients taking Warfarin, Enoxaparin, Xarelto, Eliquis and other anticoagulant medications. The patient population I serve is made up of people from diverse backgrounds in Hartford and the surrounding suburbs. There are over 500 patients in our clinic. Patients are taking anticoagulant medications because they have had dangerous blood clots that may be life-threatening or to prevent blood clots that could cause a debilitating stroke. Their therapy requires close management to minimize adverse events such as serious bleeding or clotting and improve adherence to their medications.

Since the pandemic started, it impacted how we manage patients taking warfarin. Patients that take warfarin require periodic INR blood testing which may be from once weekly to once every 6 weeks depending on how stable a patient is on their therapy. As part of our CDTM protocol, I can modify their therapy to achieve and maintain a therapeutic INR as well as order other lab work pertaining to their therapy. Because of needing required lab work and the feasibility of doing so during a pandemic, my colleagues and I had to assess our patient population to choose appropriate patients that would benefit from a switch to a different anticoagulant that does not require frequent monitoring such as Xarelto or Eliquis, or extend the interval of INR testing. This was intended so that the patient would be able to be safe at home and avoid being exposed to Covid19 at an outpatient medical setting. The patients that would be switched to Xarelto or Eliquis would then require every 3 -6 month follow up. Patients remaining on warfarin were given the option for INR management through drive up testing provided at our clinic, in-clinic testing, lab testing, and even self-testing where appropriate. To achieve this, available guidelines were utilized to create an anticoagulation plan in addition to our already documented protocol. All documentation pertaining to the patient's care is placed into an electronic medical record which is viewable by the collaborating physicians or nurse practitioner. It is burdensome to report every 30 days to the referring physician or APRN especially since the technology is available to view the patient's care at any time.

This bill as proposed **does not change pharmacist scope of practice.** It eliminates an outdated administrative burden for pharmacists, physicians, and APRNs engaging in this agreement that was created prior to the availability of shared electronic medical records. It also provides clarification that a written protocol within a CDTM agreement may include guideline-directed management.

Utilizing a CDTM protocol provides a blueprint to manage our patients' care safely and accurately according to published guidelines that are continually updated. In providing the option to document information in a shared medical record vs a 30-day report will remove some burden from the pharmacist, physician, APRN involved in the CDTM.

Thank you for your time and consideration of this bill.

Karen Gleason, PharmD BCACP CACP