**Appendix 3**

**Common Medication Regimen Adjustments through Telephone Intervention Service**

**Case 1:**

72 year old man with a history of PD for 12 years, with end of dose wearing off, constipation, orthostatic hypotension, mild cognitive impairment with recent MMSE 25/30.

PMH: GERD, diabetes mellitis type 2, CAD with CABG 5 years ago, atrial fibrillation, osteoarthritis, gout

***Medications:***

Levodopa/carbidopa 100/25 1.5 tabs q3h at 800/1100/1400/1700/2000; 1 tab at 2200

Levodopa/carbidopa CR 100/25 at 2200

Pramipexole 0.5 mg po tid

Midodrine 5 mg po tid at 800/1200/1600

PEG 3350 8.5 gm po daily

Bisoprolol 1.25 mg po daily

Rivaroxaban 15 mg po cc supper

Domperidone 10 mg po bid

Metformin 500 mg po bid cc

Vitamin D 1000 iu po daily

Acetaminophen 650 mg po tid

Allopurinol 100 mg po daily

***Telephone call:***

Wife called about patient having worsening visual hallucinations over the past 2 weeks, seeing strangers in his home in the evening. He was very agitated. When attempting to chase them out, he almost fell. Wife was very stressed and planned to bring him to ED if this was not resolved soon. She denied any recent constitutional symptoms. There was no concern of constipation or loss of appetite, but he did have a weight loss of 5 to 10 lb over the past few months. Home BP measurements are reasonable, without significant orthostatic drop.

***Issues:*** Psychosis with possible underlying early Parkinson’s dementia, exacerbated by pramipexole, and given recent weight loss, levodopa had higher effects.

***Intervention:***

Advised to reduce pramipexole to 0.25 mg po tid for 2 weeks, then 0.125 mg po tid, with prescription faxed to pharmacy for blister pack. Quetiapine 6.25-12.5 mg bid prn for hallucinations with agitation

***Outcome:***

Pharmacist followed up with patient in 1 week. Patient did not go to ED. Patient’s hallucinations became less troublesome and he was no longer agitated. Advised to continue taper down Pramipexole and return to clinic sooner for further evaluation re: weight loss, cognition, and medication regimen.

**Case 2:**

86 year old woman with a history of PD for 6 years (akinetic rigid subtype), Parkinson’s disease dementia (PDD) for 2 years, REM sleep disorder, depression, mild dysphagia (on minced diet), constipation. She has poor mobility, with prominent freezing of gait and postural imbalance. She walks short distances with a walker with her live-in caregiver.

PMH: Breast cancer (treated with lumpectomy and radiation) 20 years ago, hypertension, osteoporosis, back pain with osteoarthritis, hypothyroidism.

***Medications:***

Levodopa/carbidopa 100/25 1.5 tablets po qid

Duloxetine 30 mg po cc breakfast

Melatonin Timed Release 5 mg po hs

PEG 3350 17 gm daily

Donepezil 5 mg po cc breakfast

Amlodipine 2.5 mg po daily

Risedronate DR 35mg po daily

Vitamin D 1000 iu po daily

Calcium 500 mg po daily

Acetaminophen 1 gm po tid

Levothyroxine 0.05 mg po daily

***Telephone call:***

Live- in caregiver called about patient not eating well for the past week. She became too tired during the day to do anything and was up at night. She was more confused, and kept asking caregiver to bring her “home”.

Pharmacist inquired about other symptoms systematically. She had refused to take PEG 3350 for the past 2 weeks and her last bowel movement was 3 days ago. She has been having lumps of hard stool (Bristol type 1) every few days over the past 2 weeks. Her blood pressure, taken at home, was 100/60 sitting. She has not had any fever, but is passing small volumes of urine more frequently.

***Issues***: Constipation and fecal impaction (due to medication non-adherence), leading to poor intake, dehydration, likely some urinary retention and delirium

***Intervention:***

Advised to use sodium phosphate (Fleet) enema daily for 2 days, bisacodyl suppository 10mg PR qpm for 3 days, then bisacodyl 10 mg po hs PRN if no BM that day. Increase PEG 3350 to 17 gm po bid for 1 week, then 17gm po daily.

Hold amlodipine. Reassess BP at home daily. Resume amlodipine if BP above 150/90.

***Outcome:***

Pharmacist called caregiver the next 2 days. Patient had several large bowel movements and she was slowly drinking and eating better. She became more alert and less confused. Amlodipine was resumed 2 weeks later. Patient did not go to ED.