Print Form Reset Form

Date/Time Received by MRx Quality:	
Tracking # Assigned:	

Member Drug Error Report

Pharmacy name where drug was received: _____

Date the drug was received: _____

Date drug error was identified: _____

Date Error Reported to Magellan Rx Management: _____

Definitions

What does this mean?	
Drug Error	Any mistake in the drug you received that is different from what your doctor wrote. Examples include: received a drug my doctor did not order for me, received the wrong drug; received the wrong dose of the drug, received the wrong dosage form of the drug such as pill when liquid was ordered, received another person's drug, received too many pills, did not receive enough pills, received a drug that had expired, received a drug that was not stored at the right temperature,

Member Demographics

Member Name	Member ID	Member Plan	Patient
			☐ Member was **the patient**. ☐ Member was **NOT** the patient.

If the member was not the patient (intended recipient of the medication) please enter the following:

Intended Recipient's Name	Age	Relationship to Member

Complete the following information regarding the *drug*:

Drug Name	
Pharmacy Rx Number on Bottle	
Ordering Doctor	

Please provide a narrative description of all *the events* surrounding the *drug error. Please answer to the best of your ability all the questions below. You may use more paper.*

Questions	Description
How was the mistake found?	
Was the mistake found before the member (or the patient) took their first dose? **If NO, how many doses were taken?**	☐ YES ☐ I do not know ☐ NO
Was your doctor told? **If NO, please indicate the reason why.**	☐ YES Date: ☐ NO
Did the member (or the patient) have anything bad happen because of taking the drug? **If YES, please give details.**	☐ NO ☐ I do not know ☐ YES
Did the member (or the patient) see a doctor because of what happened? **If YES, please give more details**	☐ NO ☐ I do not know ☐ YES
Was your pharmacy told they had made a mistake? **If NO, please indicate the reason why.**	☐ YES Date: ☐ NO
Did the member (or the patient) later get the correct drug? **If NO, please explain.**	☐ YES Date: ☐ NO

Name of Person Completing Form: _____

Can we call you if we have questions? ☐ **NO** ☐ **YES**

Telephone Number: _____

Best Days and Time(s) to Call: _____

Thank you for completing this form. To make sure we receive this report, please send the completed form to Magellan Rx Management by web, email, or mail as outlined in the instructions provided on our website. Email and address are also noted below:

Email: MRxQualityDepartment@magellanhealth.com
Mail: Magellan Rx Management
Attention Quality Department
11013 W. Broad St, Suite 500
Glen Allen, VA 23060