

DRUG THERAPY MANAGEMENT **INSTRUCTION SHEET**

Below is a checklist to follow when submitting an application for participation in Drug Therapy Management pursuant to: Health Occupations Article, 12-6A-01 through 12-6A-10 of the Annotated Code of Maryland and COMAR 10.34.29.01 - .07. Below is a link to the Code of Maryland Regulations for Drug Therapy Management. Please note that the Board of Pharmacy is receiving all application materials on behalf of the Board of Physicians.
http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.34.29.* (Click on the blue numbers on the left for the complete text.)

1. Complete a Pharmacist's Information Form for each pharmacist who will be performing Drug Therapy Management under the Physician- Pharmacist Agreement.
2. Complete the Application for Participation in Drug Therapy Management.
3. **Submit to the Maryland Board of Pharmacy** at 4201 Patterson Avenue, Baltimore, MD 21215:
 - a. The completed Pharmacist's Information Form;
 - b. The completed Application for Participation in Drug Therapy Management;
 - c. The Protocol;
 - d. The Physician-Pharmacist Agreement; and
 - e. A check in the amount of One Hundred Dollars (\$100.00) made payable to the Maryland Board of Pharmacy.
4. After reviewing the Pharmacist Information Form and verifying appropriate licensure of the physician(s), the Board of Pharmacy will acknowledge in writing receipt of the complete application packet, the fee, and if any additional information is required.
5. **The contact person named in the application will submit to the Board of Pharmacy:**
 - a. Subsequent amendments to the Protocol or Physician-Pharmacist Agreement; and
 - b. Changes to participants of the Protocol or Physician-Pharmacist Agreement.
6. The Board of Pharmacy will forward all materials to the Board of Physicians for their records.

PHARMACIST'S INFORMATION FORM
DRUG THERAPY MANAGEMENT

Each pharmacist who is to perform drug therapy management under this Physician-Pharmacist Agreement must complete a Pharmacist Information Form. The purpose of the form is to provide information to the Board of Pharmacy so that the Board may determine if each pharmacist has the basic qualifications to perform under this Physician-Pharmacist Agreement. The Board of Pharmacy must approve each pharmacist.

Pharmacist's Name _____
 Last First Middle Generation (Sr., Jr., etc.)

1. Status of Pharmacist's License.

A. License Number: _____

B I have not had a public final order disciplining my pharmacist's license in Maryland or in any other state within the 5 years immediately preceding this application. If you have had a public final order disciplining your pharmacist's license within the 5 years immediately preceding this application, please stop here. You are not eligible to provide drug therapy management.

 I was disciplined by the Board of Pharmacy or by any other state more than 5 years ago and currently my license has limitations place on it. If you indicated that you currently have limitation placed on your pharmacist's license, please stop here. You are not eligible to provide drug therapy management.

2. Education and Training.

Please feel free to attach an additional document if more space is required to answer the following questions. Be sure that you make clear which answer accompanies which question.

I possess a Doctor of Pharmacy degree. (If you checked this box, please skip to section 3.)

School from which degree obtained: _____

Year that degree was obtained: _____

I possess a Bachelor of Science in Pharmacy degree and I have training in the areas listed below. I am providing documentation for each item listed below and/or an explanation (a Formal Job Description or a Job Performance Evaluation Form from the pharmacist's employer, listing these tasks would suffice).

A. Designing, implementing, monitoring, evaluating, and modifying or recommending modifications in drug therapy to ensure effective, safe, and economical patient care.

B. Identifying, assessing, and solving medication-related problems, and providing clinical judgments as to the continuing effectiveness of individualized therapeutic plans and intended therapeutic outcomes.

C. Conducting appropriate physical assessments, evaluating patient problems, and ordering and monitoring medications and laboratory tests in accordance with established standards of practice.

D. Monitoring patients and patient populations regarding the purposes, uses, effects, and pharmacoeconomics of their medications and related therapy.

E. Providing emergency care including cardiopulmonary resuscitation.

F. Using clinical data to optimize therapeutic drug regimens.

G. Documenting interventions and evaluating pharmaceutical care outcomes.

3. Advanced Training.

Please indicate that you possess or have completed at least one of the following advanced training programs or certification processes and attach any necessary documentation that indicates name, nature, completion date, expiration date as applicable:

The Board of Pharmacy Specialties Certification program

The American Society of Consultant Pharmacist's Certified Geriatric Practitioner certification program

A residency offered by a body accredited by the Accreditation Council on Pharmacy Education (accrediting bodies for residencies include organizations such as the American Pharmaceutical Association and the American Society of Health-Systems Pharmacists)

Other(provide description, issue date/completion date, and Expiration date, as applicable):_____

4. Hours of Experience (Please check at least one).

I have successfully completed 1,000 hours of relevant clinical experience.

I have successfully completed 320 hours in a structured experience program such as a residency or certification program.

5. Signature.

By signing this Pharmacist Information Form, I am requesting that I be approved to perform drug therapy management pursuant to the accompanying Physician-Pharmacist Agreement and protocol or protocols. I solemnly affirm under the penalties of perjury that the contents of this application are true to the best of my knowledge, information, and belief.

Signature

Date

**APPLICATION FOR PARTICIPATION IN
DRUG THERAPY MANAGEMENT**

(Health Occupations Article, 12-6A-01 through 12-6A-10, Annotated Code of Maryland
and COMAR 10.34.29.01 - .07)

Drug Therapy Management is a voluntary, written arrangement that is disease-specific between a pharmacist, physician and a patient receiving care from a physician and a pharmacist pursuant to a physician-pharmacist agreement and protocol. It is related to treatment of the patient using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations for the purpose of improving patient outcomes. To apply to participate in Drug Therapy Management the applicant must submit to the Board of Pharmacy a physician-pharmacist agreement signed by all physicians and pharmacists engaged in the drug therapy management agreement. All participating pharmacists are required to complete a Pharmacist Information Form which sets forth the pharmacist's qualifications, expertise and experience to participate in Drug Therapy Management. Additional documentation to support the pharmacist's expertise and experience may also be submitted along with the fee of \$100 per physician-pharmacist agreement.

1. Contact person's information:

Every physician-pharmacist agreement must have a primary contact person. This is the person with whom the Boards of Physicians and Pharmacy will correspond. It is this person's responsibility to relay information to the other individuals who are acting under the physician-pharmacist agreement in a timely manner. If the contact person's information changes, it is the responsibility of the contact person to notify, and to provide the new contact information to, the Boards of Physicians and Pharmacy within 30 days of the change.

Contact's Name _____
Last First Middle Generation (Sr., Jr., etc.)

Mailing Address _____
Number and Street Suite

City State Zip Code

Telephone Numbers: Day() _____ Other () _____

Pager () _____ Fax () _____

Email address: _____
(Required)

Contact Person's Profession Physician Pharmacist

License Number: _____

I agree to provide information provided by the Boards of Physicians or Pharmacy to the other parties to this Physician-Pharmacist Agreement in a timely manner and to notify the Board of Pharmacy of any change in my contact information within 30 days of the change.

Signature _____ Date _____

2. Physician or physicians to work pursuant to this Physician-Pharmacist Agreement.

If more than five physicians are to work pursuant to this Physician-Pharmacist Agreement, please provide the information below on a separate document and include that document with this application.

A. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

B. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

C. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

D. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

E. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

3. Pharmacist or pharmacists to work pursuant to this Physician-Pharmacist Agreement.

Pharmacists who work pursuant to this Physician-Pharmacist Agreement must be approved by the Board of Pharmacy. Please complete a *Pharmacist Information Form*, which is a separate document, for each pharmacist that you list below and provide that from with this application. If more than five pharmacists are to work pursuant to this Physician-Pharmacist Agreement, please provide the information below on a separate document and include that document with this application.

Pharmacists:

A. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

B. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

C. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

D. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

E. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

4. Protocols under which the parties will perform drug therapy management.

A. Name of Protocol: _____

B. Name of Protocol: _____

C. Name of Protocol: _____

D. Name of Protocol: _____

E. Name of Protocol: _____

Be sure to include any documentation you believe to be pertinent to the listed protocols. If you are submitting more than five protocols, please provide on a separate document, the name of protocols not listed on this form.

5. Fee

The Board of Pharmacy requires a fee for the physician-pharmacist agreement and protocol application (which includes review of the qualifications of the pharmacist participants) of \$100 per physician-pharmacist agreement. Please make the check payable to: The Board of Pharmacy.

6. Please complete the following checklist before your original application is submitted to the Board of Pharmacy:

- The Physician-Pharmacist Agreement has been signed by all physicians and pharmacists who will be engaged in the drug therapy management agreement.
- A Pharmacist Information Form has been completed for each pharmacist who is to be engaged in the drug therapy management agreement.
- Documentation to support pharmacist(s)' expertise and experience in the protocol(s).
- The fee.

8. Signature.

By signing this application, I solemnly affirm under penalties of perjury that the contents of this application are true to the best of my knowledge, information, and belief.

Signature of Contact Person

Date