THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Pharmacy
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Pharmacist Collaborative Practice Agreement Application

A collaborative practice agreement is specific to the pharmacist's practice per 12 AAC 52.240(a) and is not specific to particular pharmacists or practitioners. An approved collaborative practice agreement authorizes all employed pharmacists to engage in the protocols indicated below.

☐ **New Protocol**	☐ **Modification of Existing Protocol; Collaborative Practice # _____**		☐ **Termination of Protocol; Collaborative Practice # _____**	
Protocol Type:	☐ Ropivacaine Nerve Block	☐ Travel Medication	☐ Immunizations	☐ Hypertension
	☐ Emergency Contraception	☐ Anticoagulation	☐ Other Emergency Medication	

PART I Pharmacy Information

Pharmacy Name:	
Alaska Pharmacy License #:	
Pharmacy Physical Address:	Street: City: State: Zip Code:
Pharmacy Email:	

PART II Pharmacist Information

Name of Collaborating Pharmacist:	
Pharmacist License #:	
Pharmacist Phone #:	
Pharmacist Email:	

Are you the pharmacist-in-charge? **YES** ☐ **NO** ☐

List additional participating pharmacists involved in this collaborative practice agreement if known. ***(Attach additional pages if necessary.)***

Pharmacist Name	Alaska License Number	Expiriation Date

PART III Practitioner Information

Name of Prescribing Practitioner:	
Type of Practitioner:	
Practitioner License #:	
Practitioner Phone #:	
Practitioner Email:	
Practitioner Employer:	

PART IV Collaborative Practice Protocol Details (12 AAC 52.240)

1. Does the protocol contain an agreement in which practitioners authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol? **Yes** ☐ **No** ☐

2. Does the protocol contain a statement identifying the practitioners authorized to prescribe and the pharmacists who are party to the agreement? **Yes** ☐ **No** ☐

3. Is a time period for the protocol specified? (May not exceed two years) **Yes** ☐ **No** ☐

4. Does the protocol include the types of collaborative authority decisions that the pharmacists are authorized to make, including:

a. types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case?

b. procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved?

Yes ☐ **No** ☐

5. Does the protocol include activities the pharmacists are to follow in the course of exercising collaborative authority, including documentation of decisions made, and a plan for communication and feedback to the authorizing practitioners concerning the specific decisions made? **Yes** ☐ **No** ☐

6. Does the protocol contain a list of the specific types of patients eligible to receive services under the written protocol? **Yes** ☐ **No** ☐

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7. Does the protocol include a plan for the authorizing practitioners to review the decisions made by the pharmacist at least once every three months? **Yes** ☐ **No** ☐

8. Does the protocol include a plan for providing the authorizing practitioners with each patient record created under the written protocol? **Yes** ☐ **No** ☐

9. Are the authorizing practitioners in active practice, and is the prescriptive authority within the scope of the practitioners' practice? **Yes** ☐ **No** ☐

10. Does the protocol specify and require completion of additional training, if required for the procedures authorized under the protocol? **Yes** ☐ **No** ☐

11. If the practitioner is a physician licensed under the State Medical Board, has that physician received approval from the State Medical Board under 12 AAC 40.983 to enter into this agreement? If no, explain:

_____

_____

_____

Yes ☐ **No** ☐

☐ **ATTACH A COPY OF YOUR WRITTEN PROTOCOL**

FOR PHARMACISTS

By providing my signature below, I acknowledge that a signed copy of the approved collaborative practice application and protocols must remain at the pharmacy location at all times as required by 12 AAC 52.240(i).

FOR PRACTITIONERS

By providing my signature below, I acknowledge that I will also comply with all provisions required by the State Medical Board's Collaborative Practice Agreement regulations.

Signature of Collaborating Pharmacist:		**Date:**	(mm/dd/yyyy)
Signature of Practitioner:		**Date:**	(mm/dd/yyyy)