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–state 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 and mail to Maryland Board of Pharmacy, P.O. Box 2051, Baltimore, MD 21203-2051.

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 engaged in the drug therapy management agreement.

☐ Documentation to support pharmacist(s)'expertise and experience in the protocol(s).

☐ The fee.

7. 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

PRINT FORM CLEAR FORM