*Sample Rhode Island Collaborative Practice Agreement for chronic disease (i.e. hypertension, diabetes, dyslipidemia, etc.), medication therapy management and/or collaborative drug therapy management*

*Input PRACTICE LOGO and ADDRESS*

**COLLABORATIVE PRACTICE AGREEMENT**

1. **PURPOSE**

This Collaborative Practice Agreement (CPA) is made by and among (*company name/physicians*) working in collaboration with (*name of clinical pharmacists*) for the purpose of managing and/or treating patients pursuant to the parameters outlined in this agreement.

1. **AUTHORITY**

This authority follows the Rhode Island Rules and Regulations for the Licensure and Discipline of Physicians (R5-37-MD/DO) and the Rules and Regulations Pertaining to Pharmacists, Pharmacies and Manufacturers, Wholesalers and Distributors (R5-19.1-PHAR).

1. **PARTIES TO THE AGREEMENT**

The following providers agree to the parameters outlined in this agreement:

 **C.1 Pharmacists**

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacist Name | Credentials | Qualifications Certifications/ Licenses | Contact Information |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 **C.2 Physicians**

|  |  |  |  |
| --- | --- | --- | --- |
| Prescriber Name | Title | Practice Location  | Contact Information  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **SITE AND SETTING FOR COLLABORATIVE PRACTICE**

**D.1 Site-** *Name and address of practice location(s)*

**D.2 Setting-** *On site visit/Telephonic encounters/ Direct mailing/ Secure electronic communication (if applicable)*

1. **PATIENT**

**E.1** Patients whose therapy may be managed pursuant to this agreement include those *(who have been diagnosed by a health care provider with hypertension, diabetes, dyslipidemia, and/or tobacco dependence, etc.)* by a prescriber listed in Section C.2.

**E.2** Physician(s) pursuant to Section C*.*2 confer consent *by referral to pharmacist(s) pursuant to Section C.1 or by approval of the pharmacist(s) request for patient care collaboration.*

1. **PATIENT CARE FUNCTIONS AUTHORIZED**

Pharmacists included in Section C.1 of this agreement will have the authority to manage and/or treat patients in accordance with this section. Such management and treatment shall only be in agreement with

In managing and/or treating patients, the pharmacist(s)…..*may authorize medication initiation, continuation of drug therapy, modification of dose(increase or decrease) , medication discontinuation, or modification of drug therapy to a therapeutic alternative medication, if appropriate based on current literature and clinical judgement. The pharmacist(s) may order laboratory tests and exercise other patient care medication management measures related to monitoring or improving drug therapy outcomes.*

*Medications initiated, modified or discontinued will be in accordance with nationally accepted, evidence-based documents providing clinicians with up to date recommendations, treatment goals and best practices for improving health outcomes in the following chronic conditions:*

*(List chronic conditions, authority, guidelines, medication classes)*

**F.1 Diabetes Mellitus**

**F.*1a*** *Pharmacist(s) may authorize medication initiation, adjust dose, modify drug therapy to a therapeutic alternative medication or discontinue a medication*

**F.*1B*** *Pharmacist(s) may authorize DME supplies including glucometer, test strips, lancets and associated items and also may authorize insulin administration devices including but not limited to syringes, needles and pen needles.*

***F.1C*** *Pharmacist(s) will evaluate diabetes mellitus therapy as outlined in the American Diabetes Association Diabetes Care: Standards of Medical Care in Diabetes*

***F.1D*** *Medication classes to include but not limited to biguanides, sulfonylureas, thiazolidinediones, glucagon like peptide 1 agonists (GLP1 agonists), sodium/glucose cotransporter 2 inhibitors (SGLT2 inhibitors), dipeptidyl peptidase-4 (DPP-4) inhibitors, meglitinides, insulin*

**F.2 Dysipidemia**

**F.2a** *Pharmacist(s) may authorize medication initiation, adjust dose, modify drug therapy to a therapeutic alternative medication or discontinue a medication*

***F.2b*** *Pharmacist(s) will evaluate hyperlipidemia therapy as outlined in the AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol*

***F.2c*** *Medication classes to include but not limited to HMG CoA reductase inhibitors (statins), cholesterol absorption inhibitors, fibrates, omega 3 fatty acids, niacin*

**F.3 Hypertension**

**F.3a** *Pharmacist(s) may authorize medication initiation, adjust dose, modify drug therapy to a therapeutic alternative medication or discontinue a medication*

***F.3b*** *Pharmacist(s) will evaluate hypertension therapy as outlined in ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines*

***F.3c*** *Medication classes to include but not limited to beta blockers, calcium channel blockers, ACE inhibitors, angiotensin receptor blockers, diuretics, alpha-blockers, vasodilators (such as hydralazine)*

**F.4 Tobacco Cessation**

**F.4a** *Pharmacist(s) may authorize medication initiation, adjust dose, modify drug therapy to a therapeutic alternative medication or discontinue a medication*

***F.4b*** *Pharmacist(s) will follow evidence based guidelines for product selection and the provision of behavioral counseling.*

***F.4c*** *Medication classes to include but not limited to varenicline, bupropion SR and nicotine replacement products.*

1. **TRAINING/EDUCATION**

All parties to this agreement are expected to maintain up to date competencies and knowledge of current guidelines for disease states covered under this agreement

1. **LIABILITY INSURANCE**

All parties to this agreement shall maintain professional liability insurance during the term of the agreement

1. **PATIENT INFORMED CONSENT**

Patients referred by prescribers to pharmacist(s) for collaborative practice management shall provide written informed consent upon first meeting. A record of provision of care by a pharmacist shall be maintained in the patient’s medical record.

1. **DOCUMENTATION**

The pharmacist(s) shall document each initiation, modification, or discontinuation of medication therapy in the patient’s electronic medical record. Documentation shall also include other pertinent information including changes in patient conditions, telephone encounters, test results and patient assessment.

1. **COMMUNICATION**The pharmacist shall provide the patient’s prescriber with notification in the electronic medical record upon therapy initiation, modification or discontinuation pursuant to this agreement.All care provided to thepatient by the pharmacist will be in coordination with the provider.
2. **CROSS COVERAGE**

A licensed Provider will be available for consultation during pharmacy clinic operations. In case of illness or vacation of the Primary Care Provider and/or Clinical Pharmacist, the covering Primary Care Provider and/or Clinical Pharmacist will be consulted.

1. **QUALITY ASSURANCE**

Care provided as a result of this collaborative practice agreement will be routinely evaluated to assure delivery of high quality patient care. Annual evaluation of pharmacist(s) may include clinical outcomes and assessment of quality of care.

1. **AGREEMENT REVIEW AND DURATION**

This agreement shall be valid for a period not to exceed two years from the effective date. A review or revision may occur at any time at the request of the signatories.

1. **RECORD RETENTION**

Each signatory to this agreement shall keep a signed copy, written or electronic, of this agreement on file at their primary place of practice.

1. **RESCINDMENT OR ALTERATION OF AGREEMENT**

A signatory may rescind from this agreement or a patient may withdraw from treatment under this agreement at any time.

1. **REFERENCES:**
2. **AGREEMENTS**

We, the undersigned physician(s), authorize the undersigned pharmacist(s) to manage and/or treat patients pursuant to the parameters outlined in this agreement and do hereby agree to this collaborative practice agreement. This authority follows the Rhode Island Rules and Regulations for the Licensure and Discipline of Physicians (R5-37-MD/DO) and the Rules and Regulations Pertaining to Pharmacists, Pharmacies and Manufacturers, Wholesalers and Distributors (R5-19.1-PHAR).

 **SIGNATURES:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

 **(Prescriber Name and Credentials) (Prescriber Signature) (RI License #). (Date)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

 **(Prescriber Name and Credentials) (Prescriber Signature) (RI License #). (Date)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

 **(Pharmacist Name and Credentials) (Pharmacist Signature) (RI License #). (Date)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

 **(Pharmacist Name and Credentials) (Pharmacist Signature) (RI License #). (Date)**

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