Collaborative Practice Agreement

[community pharmacy name]

[address]

[phone number]

[physician practice]

[address]

[phone number]

Effective: [date]

Expiration: [date]

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1.0 Introduction

1.1 Background

- A collaborative practice agreement (CPA) must be a written document that specifies what disease states pharmacists can help manage; what drugs or drug categories pharmacists can utilize; what protocol pharmacists will follow when adjusting medication therapy; and how pharmacists and physicians will communicate.

- [brief background of collaboration between community pharmacy and physician practice]

1.2 Authority and Purpose

- I, [medical director name], authorize the pharmacists named herein, who hold an active license to practice issued by [state], to manage and/or treat patients pursuant to the parameters outlines in this agreement. This authority follows the laws and regulations of [state].

- [Community pharmacy] and [physician practice] are committed to providing high quality care in the most affordable, efficient way. Creation of multi-disciplinary teams who can function as physician extenders are one way to achieve these goals and provide excellent patient care. The purpose of this agreement is to enhance collaborative patient care and optimize medication-related outcomes for mutual patients of [community pharmacy] and [physician practice].

1.3 Collaborating Professionals

- Physicians of [physician practice]
  [address 1]
  [address 2]
  [phone]
  [fax]

- Pharmacists of [community pharmacy]
  [address 1]
  [address 2]
  [phone]
  [fax]

1.4 Patients

- Patients whose therapy may be managed pursuant to this agreement include those who are currently receiving primary care by a physician of [physician practice] and pharmaceutical care by a pharmacist of [community pharmacy] for the medical indications detailed in this agreement.

1.5 Goals

- To optimize drug therapy
- To reach clinical health targets and quality metrics
- To improve patient adherence and medication access
- To increase access and efficiency of primary care physicians
- To decrease preventable emergency room visits and hospital readmissions
- To improve the health of patients and their quality of life

2.0 Diabetes Management

2.1 Quantity Adjustments

- Pharmacists may adjust drug quantities on prescriptions for the treatment of diabetes to dispense at least a 30-day supply (i.e. quantity of insulin vials).

2.2 Formulation Interchange

2.2.1 Combination Products

- Pharmacists may combine individual prescriptions medications into combined formulations when available. (i.e. Januvia + Metformin = Janumet)
- Pharmacists may separate prescription combination products into their individual components when the combination product is not available. (i.e. Janumet = Januvia + Metformin)

2.2.2 Time-Release Products

- Pharmacists may interchange immediate release products for extended-release products (including sustained, delayed, and controlled) based on medication availability and tolerability. (i.e. Metformin = Metformin ER)
- Pharmacists may interchange extended-release products (including sustained, delayed, and controlled) for immediate release products based on medication availability and tolerability. (i.e. Metformin ER = Metformin)

2.3 Therapeutic Interchange

2.3.1 Insulin

- Pharmacists may interchange between short-acting and rapid-acting insulin products at equivalent dosing 1:1.
- Insulin glulisine (Apidra), insulin lispro (Humalog), regular human insulin (Humulin R), and insulin aspart (Novolog)
- Pharmacists may interchange between mixed insulin products at equivalent dosing 1:1.
- Insulin lispro/NPH (Humalog 75/25), regular human insulin/NPH (Humulin 70/30, Novolin 70/30), and insulin aspart/NPH (Novolog 70/30)
- Pharmacists may interchange between basal insulin products at equivalent dosing 1:1.
- Insulin glargine (Lantus, Basaglar, Toujeo), insulin detemir (Levemir), and insulin degludec (Tresiba)
- Standard dosing conversation (see Appendix 2.3.1)

2.3.2 Sulfonylurea

- Pharmacists may interchange between sulfonylureas at equivalent dosing.

- Glipizide (Glucotrol), glimepiride (Amaryl), and glyburide (Glynase)
- Standard dosing conversions (see Appendix 2.3.2)

2.3.3 DPP-4 Inhibitors

- Pharmacists may interchange between dipeptidyl peptidase-4 (DPP-4) inhibitors at equivalent dosing.
- Alogliptin (Nesina), linagliptin (Tradjenta), saxagliptin (Onglyza), and sitagliptin (Januvia)
- Standard dosing conversions (see Appendix 2.3.3)

2.3.4 SGLT-2

- Pharmacists may interchange between selective sodium-glucose transporter-2 (SGLT-2) at equivalent dosing.
- Canaglifozin (Invokana), empagliflozin (Jardiance), and dapaglifozin (Farxiga)
- Standard dosing conversions (see Appendix 2.3.3)

2.3.5 GLP-1

- Pharmacists may interchange between glucagon-like peptide 1 (GLP-1) at equivalent dosing.
- Exenatide (Byetta, Bydureon), liraglutide (Victoza), albiglutide (Tanzeum), dulaglutide (Trulicity), and lixisenatide (Adlyxin).
- Standard dosing conversions (see Appendix 2.3.5)

2.4 Adjustments for Drug Optimization

2.4.1 Metformin Titration

- Pharmacists may authorize metformin titration to achieve target hemoglobin A1c of less than 7.0%.
- For patients currently using metformin, metformin dose may be adjusted up to 2,550mg/day in divided doses based on blood sugar response and patient tolerability.
- Pharmacists may convert metformin to an extended-release formulation to improve patient tolerability.
- ADA guidelines (see Appendix 2.5.4)

2.5 Initiation of Over-the-Counter Products by Prescription

2.5.1 Blood Glucose Testing Supplies

- Pharmacists may prescribe blood glucose testing supplies, including blood glucose monitors, test strips, lancets, alcohol swabs, and lancing devices.
- Pharmacists may authorize 30-day supply with one-year refills at a testing frequency adequate for optimal blood glucose control.

2.5.2 Injection Supplies

- Pharmacists may prescribe syringes and pen needles for use with anti-diabetic medications.
- Pharmacists may authorize 30-day supply with one-year refills at an injection frequency adequate for optimal blood glucose control.

2.5.3 Hypoglycemia Treatment

- Pharmacists may prescribe glucose products (tablets, gel, etc.) for the acute treatment of hypoglycemia.
- Pharmacists may authorize 30-day supply with one-year refills at frequency adequate for optimal blood glucose control.

2.5.4 Aspirin

- Pharmacists may prescribe Aspirin 81mg once daily for primary and secondary heart attack and stroke prevention for patients with diabetes aged 50 years or greater with the following considerations:
- One additional major risk factor (family history of premature ASCVD, hypertension, dyslipidemia, or tobacco use)
- Not currently using other antiplatelet or anticoagulant therapy
- Not at an increased risk of bleeding
- No allergy or intolerance to NSAIDs
- Pharmacists may authorize 30-day supply with one-year refills to be used once daily.
- Current treatment guidelines (see Appendix 2.5.4)

3.0 Tobacco Cessation Management

3.1 Initiation of Nicotine Replacement Therapy

- Pharmacists may prescribe all strengths and formulations of nicotine replacement therapy, including patches, lozenges, gum, inhalers, and nasal sprays.
- Pharmacists may prescribe up to 4 weeks of nicotine replacement therapy with no refills.
- Patients may return to the pharmacist for tobacco cessation counselling, re-evaluation, and prescriptions for appropriate next course of therapy.
- Current treatment guidelines (see Appendix 3.1)

3.2 Initiation of Varenicline (Chantix)

- Pharmacists may prescribe varenicline for the treatment of tobacco cessation for patients with undiagnosed, uncontrolled mental health conditions.
- Prior to prescribing varenicline, pharmacists will conduct the Patient Health Questionnaire (PHQ-9) with the patient to assess for undiagnosed, uncontrolled mental health conditions. Patients with a PHQ-9 score of less than 10 will be considered eligible for varenicline therapy.
- Patients using prescription medications for the treatment of mental health conditions will be excluded from pharmacists' prescribing of varenicline.
- Patient Health Questionnaire (PHQ-9) (see Appendix 3.2)

4.0 Organization

4.1 Provider Eligibility

- Physicians of [physician practice] and pharmacists of [community pharmacy] are considered qualified providers to participate in patient-care activities related to this agreement.
- All providers must be licensed in good standing with their respective board and follow established standards for entering and managing a collaborative practice agreement.
- Pharmacy interns may participate in patient-care activities related to this agreement, but must receive signed approval by a pharmacist.
- Each provider will have an ongoing physician-patient relationship with each patient whose drug therapy is managed by a pharmacist.
- The diagnosis for which each patient has been prescribed drug therapy under the collaborative practice agreement must be within the scope of each physician's practice.

4.2 Training/Education

- All qualified personnel will receive sufficient training for their role by a member of the management team, either pharmacy manager or medical director.
- All qualified personnel are expected to maintain up-to-date competencies and knowledge of current guidelines for disease states covered under this agreement.

4.3 Liability

- Providers are not required to but are highly recommended to maintain liability insurance.
- A physician is not liable for damages in a tort or other civil action for injury or loss to person or property allegedly arising from a pharmacist's change in a drug for a patient whose drug therapy the pharmacist is managing under a consult agreement unless the physician authorized the specific drug change.
- A pharmacist is not liable for damages in a tort or other civil action for any injury or loss to person or property allegedly arising from the physician's change in a drug for a patient whose drug therapy the pharmacist is managing under a consult agreement.

4.3 Informed Consent of the Patient

- Patients are required to provide written consent for each intervention resolved by a pharmacist through this agreement.

4.4 Documentation

- All patient-care interventions resolved by a pharmacist within this agreement will be documented in MTM software as "resolved by CPA."
- All patient-care interventions resolved by a pharmacist will be documented in writing on a standardized facsimile signed by the pharmacist and patient.

- Physician practice support staff will receive facsimiles and document all patient-care interventions taken under this agreement in the electronic medical record.
- Facsimile forms will be scanned into the pharmacy's prescription processing database, serving as the hard-copy prescription.

4.5 Communication

- Interventions resolved by a pharmacist will be faxed to the physician practice within 72 hours of the patient-care action taken using a standardized facsimile. (Appendix 4.5)
- The rationale for each intervention and a recommendation for a timeline for physician follow-up will be documented on the facsimile.
- The physician must review the actions of the pharmacist within a timely manner. In the event a physician disagrees with a decision made by the pharmacist under this agreement, the referring physician is permitted to override that pharmacist's decision by communicating the overridden action via fax.
- Routine communication will be conducted through telephone, fax, or secure email as is appropriate for the situation.
- The pharmacy manager and medical director will meet quarterly for quality assurance and annually for quality improvement.

4.6 Quality Assurance and Improvement

- The pharmacy manager and medical director will meet quarterly to review the activities related to this agreement for quality assurance. Policies and procedures will be revised as needed to promote safe, effective, and efficient patient care.
- The pharmacy manager and medical director will meet annually to complete a minimum of 10 chart reviews that utilized this agreement. Strategies for improvement will be discussed, and the pharmacist will develop a quality improvement plan based on the review.

4.7 Period of Validity

- This agreement is valid for up to 2 years following signatures of all parties.

4.8 Retention of Records

- All records, whether physical or electronic, must be maintained for at least 3 years.

4.9 Rescindment and Amendment

- The physician, pharmacist, or patient may withdraw from the agreement at any time with a written notice of termination.
- Prescribers may override this agreement whenever they deem such action necessary or appropriate for a specific patient intervention without affecting the agreement relative to other patients.
- This agreement may be amended prior to the 2-year expiration date.

- Amendments must include detailed policies and procedures of changes to this agreement. Amendments must be dated and signed by both parties.

5.0 Signatures of Approval

I, [medical director], a licensed healthcare provider authorized to prescribe medication in the State of [state], delegate prescriptive authority to the pharmacists listed below to initiate, modify, refill, and discontinue drug therapy for patients shared by the [physician practice] and [community pharmacy]. This authority pertains to the protocol established in this agreement in accordance with all state laws and regulations.

Pharmacists shall document all drug therapy adjusted under this protocol and communicate with the healthcare team. As the authorizing prescriber, I or authorized staff under my supervision, will be available to review drug therapy adjustments by pharmacists.

This protocol will be in effect for two years unless rescinded earlier in writing by either party. Any modification of the protocol shall be treated as a new protocol, requiring signed approval from responsible parties.

Signatures of Responsible Parties:

_____	_____	_____
[medical director name] Medical Director [physician practice]	License Number	Date
_____	_____	_____
[pharmacy manager name Pharmacy Manager [community pharmacy]	License Number	Date