# TEXAS STATE BOARD OF PHARMACY

333 Guadalupe Street, Suite 3-600 ✯ Austin, Texas 78701
512-305-8000 ✯ www.pharmacy.texas.gov

## NOTIFICATION OF PHYSICIAN DELEGATION TO A PHARMACIST

## *(LIMITED AUTHORITY FOR A PHARMACIST TO SIGN A PRESCRIPTION FOR A DANGEROUS DRUG WHILE ENGAGED IN DRUG THERAPY MANAGEMENT)*

| *PHARMACIST INFORMATION* | | | |
|---|---|---|---|
| **LAST NAME** | **FIRST NAME** | **MIDDLE NAME** | **LICENSE NUMBER** |
| | | | |
| **Pharmacist Contact information** | | | |
| **PHONE NUMBER: (  )  -** | EMAIL ADDRESS: | | |

| *HOSPITAL, HOSPITAL-BASED CLINIC OR ACADEMIC HEALTHCARE INSTITUTION INFORMATION* | | |
|---|---|---|
| **NAME OFF HEALTHCARE FACILITY PRACTICE LOCATION** | **ADDRESS OF HEALTHCARE FACILITY PRACTICE LOCATION (street, city, state, zip)** | |
| | | |
| **FACILITY PHONE NUMBER & FAX NUMBER** | **DEPT. STATE HEALTH SERVICES (DSHS) TEXAS HOSPITAL FACILITY LICENSE #:** | **FACILITY TEXAS PHARMACY LICENSE #:** |
| (  )  -<br>(  )  - | | |

| *DELEGATING/SUPERVISING PHYSICIAN(S) INFORMATION (Additional space on page 2)* | | | |
|---|---|---|---|
| **LAST NAME** | **FIRST NAME** | **TELEPHONE NUMBER** | **TEXAS MEDICAL BOARD LICENSE NUMBER** |
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| *PROTOCOL, STANDING MEDICAL ORDER, STANDING DELEGATION ORDER INFORMATION:* | |
|---|---|
| **DRUG THERAPY MANAGEMENT PROGRAMS/DISEASE STATES WITHIN WHICH PRESCRIPTIONS DRUG ORDERS FOR DANGEROUS DRUGS MAY BE SIGNED BY AUTHORIZED PHARMACIST UNDER PHYSICIAN DELEGATION** | **PROTOCOL EXPIRATION DATE** |
| | |

I hereby attest that the information on this form, as well as the information on any attachment(s) to this form, is true and correct to the best of my knowledge and the information is given of my own free will. I agree that any misstatement(s) and/or omission(s) will constitute violation of the Texas Pharmacy Act, and may subject me to disciplinary action by the board.

**PRINT Page 1**

**Signature of Pharmacist** **Date**

| *PHARMACIST INFORMATION* | | | |
|---|---|---|---|
| **LAST NAME** | **FIRST NAME** | **MIDDLE NAME** | **LICENSE NUMBER** |
| | | | |

***DELEGATING/SUPERVISING PHYSICIAN(S) INFORMATION ATTACHMENT***

***(Continued from page 1)***

| LAST NAME | FIRST NAME | TELEPHONE NUMBER | TEXAS MEDICAL BOARD LICENSE NUMBER |
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**Submit this completed form and a copy of the protocol to DTM@pharmacy.texas.gov. Due to the number of applications and protocols, email submission will be the only mode of receipt and processing at TSBP. Allow 45 business days processing time once a completed application and protocol have been submitted.**

**For renewals: Please submit your application and protocol 60 days prior to the expiration date of the previous protocol to avoid any lapse or removal from the TSBP website. NOTE: Protocols MUST be signed and dated by EACH physician.**

Questions regarding the application should be sent to DTM@pharmacy.texas.gov

Written Protocols **MUST** include the following:

**A.** A statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of drug therapy management;

**B.** A statement identifying the individual pharmacist authorized to dispense drugs and to engage in drug therapy management as delegated by the physician;

**C.** A statement identifying the types of drug therapy management decisions that the pharmacist is authorized to make which shall include:
(i) a statement of the ailments or diseases involved, drugs, and types of drug therapy management authorized; and
(ii) a specific statement of the procedures, decision criteria, or plan the pharmacist shall follow when exercising drug therapy management authority;

**D.** A statement of the activities the pharmacist shall follow in the course of exercising drug therapy management authority, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning the specific decisions made. Documentation shall be recorded within a reasonable time of each intervention and may be performed on the patient medication record, patient medical chart, or in a separate log book;

**E.** A statement that describes appropriate mechanisms and time schedule for the pharmacist to report to the physician monitoring the pharmacist's exercise of delegated drug therapy management and the results of the drug therapy management; and

**F.** The expiration date of the protocol granting the authority to sign a prescription.