

CHAPTER 61-04-08
LIMITED PRESCRIPTIVE PRACTICES

61-04-08-07. Form.

1. The collaborative agreement form utilized under this section is attached as an appendix to these rules as approved by the board of medical examiners and board of pharmacy. Upon request, either board shall supply a copy of the rules and form to any interested party.
2. A copy of each collaborative agreement and subsequent amendments approved by the boards shall remain on file with the boards. Each party shall retain the original or a copy of the agreement and amendments, and either party shall provide a copy to the facility within which the agreement is operative.
3. Either board may disseminate a current listing of the individual parties who are practicing under an approved collaborative agreement.
4. More details may be provided. Further stipulations or details shall be supplied on a separate page.

History: Effective December 1, 1996. Amended October 2013.

General Authority: NDCC 28-32-02, 43-15-10(9)(12)(14), 43-15-31.4

Law Implemented: NDCC 28-32-02, 43-15-10(9)(12)(14), 43-15-31.4

APPENDIX

COLLABORATIVE AGREEMENT FORM

The pharmacists and physicians listed below are parties to this collaborative agreement, through which the pharmacist receives limited prescriptive authority under the supervision of the physician in accordance with North Dakota Century Code section 43.15-31.4 and administrative rules.

Institution **Address** **Phone**

Pharmacist Name License Number Physician Name License Number

Pharmacist Name License Number Physician Name License Number

Pharmacist Name License Number Physician Name License Number

Physician Name License Number

[Please review the administrative rules governing collaborative agreements which accompany this form before proceeding.]

1. Describe the scope and authority to be exercised by the pharmacist. (If requesting authority to initiate drug therapy, pharmacist must include credential verification.)
2. Indicate any restrictions placed on the use of certain types or classes of drugs or drug therapies under this agreement. (Note: Schedule II drugs are excluded by these rules.)
3. If appropriate, indicate any diagnosis which are specifically included or excluded under this agreement.
4. Attach any protocols or guidelines to be used in decision making or other activities contemplated under this agreement. This must include a protocol for treating acute allergic or other adverse reactions related to drug therapy.
5. Describe approved situations, if any, in which the notification time limit may be extended beyond twenty-four hours (not to exceed seventy-two hours).

Attach additional sheets if necessary.

Pharmacist Signature Date

Physician Signature Date

Pharmacist Signature Date

Physician Signature Date

Pharmacist Signature Date

Physician Signature Date

Physician Signature Date

Board of Pharmacy Approval Date

Board of Medical Examiners Approval Date