
ATTENTION
PHARMACISTS ENGAGED IN
DRUG THERAPY MANAGEMENT (DTM)

Complete the following form and maintain it at the pharmacy associated with your practice in drug therapy management – Do not submit to the Board.

Pharmacist Name: _____
License Number: _____
Practice Site: _____
Practice Address: _____
Contact Phone: _____

Pharmacist Signature: _____ Date: _____

1. For settings other than inpatient settings and group model integrated closed HMO settings, attach a copy of the written agreement between the physician and the pharmacist.
2. Retain documentation of your successful completion of all qualification requirements asset forth in regulation 6.00.30. Do **NOT** submit this information to the Board. However, be aware you may be requested to submit this information in the future.
3. For pharmacists engaged in drug therapy management in **inpatient settings and group model integrated closed HMO settings**, also attach a copy of general authorization plan required by regulation 6.00.40. This plan shall identify which physicians and pharmacists in the facility are authorized and have agreed to participate in drug therapy management. This plan shall be signed and dated by the pharmacist.

DO NOT SUBMIT THIS COMPLETED FORM TO THE BOARD