# DRUG THERAPY MANAGEMENT FORM

**COLORADO STATE BOARD OF PHARMACY**
Denver, Colorado 80202-5146
Phone (303) 894-7750
TTY: Dial 711 for Relay Colorado
www.dora.state.co.us/pharmacy

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## ATTENTION PHARMACISTS ENGAGED IN DRUG THERAPY MANAGEMENT,

You must **complete and submit** the following to the Colorado State Board of Pharmacy

**Pharmacist Name:** ______________________________

**License Number:** ______________________________

**Practice Site:** ______________________________

**Practice Address:** ______________________________

**Contact Telephone:** ______________________________

**Pharmacist Signature:** ______________________________

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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 as set 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.

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| **Please send to:** | Colorado State Board of Pharmacy<br>1560 Broadway, Suite 1310<br>Denver, CO 80202-5146 |
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| **For Board Use Only:** | | |
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| | **Date Received** | **Initials** |
| **Form** | | |
| **Written Agreement** | | |

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|---|---|---|
| Inpatient/Group Integrated HMO Setting: | ☐ Yes | ☐ No |
| If yes, General Authorization Plan included: | ☐ Yes | ☐ No |