THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Alaska State Medical Board
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Physician-Pharmacist Cooperative Practice Agreement Application

Under 12 AAC 40.983, a physician may participate in a cooperative agreement with a pharmacist by submitting this application and copy of the protocol to the State Medical Board for approval. A "cooperative practice agreement" is an agreement by which a physician authorizes a pharmacist to manage a patient's medication therapy.

The Board of Pharmacy must also endorse the approval before a physician and pharmacist can engage in the agreement. This is a joint application; there is no need to submit separate applications to each board.

PART I Application Type

Application Type:	☐ New Agreement ☐ Renewal ☐ Modification of Existing Agreement ☐ Termination of Agreement

PART II Cooperative Practice History

1. Agreement number for renewal, modification, and termination application types only:				
2. **If a modification,** describe what protocols have changed since the cooperative practice was initially issued or last renewed (e.g., new designation types added or removed):				
3. **If a renewal,** please confirm the protocols and services provided under the existing cooperative practice agreement have not changed since initially issued or last renewed, whichever is most recent. (If there have been changes, apply by modification.)				
Original Agreement Date:				
Requested Effective Dates for Agreement:*	**Start Date:**		**End Date:**	

**May not exceed two years.*

PART III Designation Types

Protocol Type:	☐ Travel Medication ☐ Immunizations ☐ Hypertension ☐ Emergency Contraception ☐ Anticoagulation ☐ Other, Please Specify: _____

PART IV Physician Information

Physician Name:		**License Number:**	
Email Address:		**Phone Number:**	
Employer Name:		**Physician Type:**	

PART V Additional Physicians

Please list additional participating physicians involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Physician Name	Alaska License Number	Expiration Date

PART VI Pharmacy Information (If Applicable)

Pharmacy Name:			
Pharmacy Email Address:		**Alaska Pharmacy License Number:**	
Pharmacy Physical Address:	Street City State Zip		

PART VII Pharmacist Information

Cooperating Pharmacist Name:		**License Number:**	
Practice Address: (If Not Pharmacy Listed Above)	Street City State Zip		
Email Address:		**Phone Number:**	

PART VIII Additional Pharmacists

Please list additional participating pharmacists involved in the cooperative practice agreement, if known. *Attach additional pages, if needed.*

Pharmacist Name	Alaska License Number	Expiration Date

PART IX Cooperative Practice Protocol Details (12 AAC 40.983)

1.	Does the protocol contain an agreement in which physicians authorized to prescribe legend drugs in this state authorize pharmacists licensed in this state to administer or dispense in accordance with that written protocol?	☐ **Yes** ☐ **No**
2.	Does the protocol contain a statement identifying the physicians authorized to prescribe and the pharmacists who are party to the agreement?	☐ **Yes** ☐ **No**
3.	Is a time period for the protocol specified? (May not exceed two years.)	☐ **Yes** ☐ **No**
4.	Does the protocol include the types of collaborative authority decisions that the pharmacists are authorized to make, including: **A.** Types of diseases, drugs, or drug categories involved and the type of collaborative authority authorized in each case? **B.** Procedures, decision criteria, or plans the pharmacists are to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved?	☐ **Yes** ☐ **No**
5.	Does the protocol include activities the pharmacists are to follow in the course of exercising collaborative authority, including documentation of decisions made, and a plan for communication and feedback to the authorizing practitioners concerning the specific decisions made?	☐ **Yes** ☐ **No**
6.	Does the protocol contain a list of the specific types of patients eligible to receive services under the written protocol?	☐ **Yes** ☐ **No**
7.	Does the protocol include a plan for the authorizing practitioners to review the decisions made by the pharmacist at least once every three months?	☐ **Yes** ☐ **No**
8.	Does the protocol include a plan for providing the authorizing physicians with each patient record created under the written protocol?	☐ **Yes** ☐ **No**
9.	Does the protocol specify and require completion of additional training, if required for the procedures authorized under the protocol?	☐ **Yes** ☐ **No**
10.	Does the protocol include a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate?	☐ **Yes** ☐ **No**
11.	Does the plan acknowledge that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement?	☐ **Yes** ☐ **No**

PART X Agreement

For Physicians: By providing my signature below, I acknowledge that I will also comply with all provisions required by the State Medical Board's Cooperative Practice Agreement regulations.

For Pharmacists: By providing my signature below, I acknowledge that a signed copy of the approved collaborative practice application and protocols must remain at the pharmacy location at all times as required by 12 AAC 52.240(i).

☐ Attach a copy of your written protocol.

Cooperating Physician Signature:		**Date Signed:**	
Cooperating Pharmacist Signature:		**Date Signed:**	