Collaborative Practice Agreement Template & Notification Letter Template

**Collaborative Practice Agreement (CPA) Template:**

**Prescribing of Tobacco Cessation Medications for Patients 18+**

**Introduction:**

As the leading cause of preventable death in Wisconsin, tobacco use and exposure claims thousands of Wisconsin lives each year and leads to an array of chronic conditions including heart disease, asthma, and lung cancer. Addiction to tobacco is a multifaceted condition which requires a multipronged approach to recovery including pharmacotherapy, behavioral modification, craving control, and regular consultation with a healthcare provider. Frequently, tobacco users who wish to quit don’t receive appropriate care from a healthcare professional in their attempt to quit and are unable to quit as a result. To increase availability of tools and counseling needed for patients to successfully quit tobacco, **[Insert Name of Pharmacy/Pharmacist(s)]**, is prepared to work collaboratively with physicians by entering into this CPA permitting pharmacists to prescribe and provide tobacco cessation medication and devices to patients who wish to quit using tobacco.

**Authority and Purpose:**

I, **[Insert Name(s) and Credentials of Physician(s) Entering into Agreement]** (i.e. the “physician(s)”), who hold an active license to practice from the State of Wisconsin to manage and/or treat patients pursuant to the parameters outlined in this agreement, delegate authority to **[Insert Name of Pharmacy or Name(s) of Pharmacist(s)]** (OR pharmacists employed by **[Insert Pharmacy Name]** who have received **[Insert required training])** (i.e. “the pharmacy/pharmacist”) to manage and/or treat patients pursuant to the parameters outlined in this agreement pursuant to the laws and regulations of the State of Wisconsin.

Wisconsin state law allows pharmacists to practice under a Collaborative Practice Agreement with individual physicians (Statute 450.033 *Services delegated by physician: A pharmacist may perform any patient care service delegated to the pharmacist by a physician, as defined in s. 448.01(5)*)*.*

448.01 Definitions. In this chapter: (5) ”Physician” means an individual possessing the degree of doctor of medicine or doctor of osteopathy or an equivalent degree as determined by the medical examining board, and holding a license granted by the medical examining board.

It is the intent of this document to authorize the pharmacy/pharmacistto work in a collaborative fashion with and under the direct supervision of the physician(s) signed below. This document establishes a framework and guidelines for collaboration between the physician and pharmacist.

**Goals:**

The goals of this agreement are to:

1. Allow pharmacists to prescribe tobacco cessation medications and devices approved by the United States Food and Drug Administration (FDA) to patients wishing to quit using tobacco.
2. Improve access to care by ensuring patient receipt of tools and assistance in a timely accordance with their desire to quit.
3. Utilize patient accessibility to pharmacists for counseling and assistance throughout a quit attempt.
4. Increase collaboration between the pharmacy/pharmacist and the physician(s).

**Policy:**

This agreement allows the pharmacist to prescribe and dispense any medications or devices approved by the Food and Drug Administration for use in tobacco cessation and to provide counseling to the patient leading up to and throughout their quit attempt.

In order to meet the criteria of this agreement, the patient must meet the following parameters:

* Age 18 years or older
* Tobacco user who has expressed a desire to quit using tobacco

In the event a patient meets the above criteria:

* The pharmacist will conduct a thorough medical history and medication history with the patient to determine the most appropriate medication therapy based on medical history, patient lifestyle, and patient preference.
* The pharmacist will consult the US Department of Health and Human Services, Public Health Services, Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update (or subsequent updates as they become available) to select appropriate medication therapy for the patient and to determine starting and continuing doses.
* The pharmacist will help the patient select a quit date and counsel the patient on strategies for use leading up to their quit date and throughout their quit attempt such as keeping a “cigarette diary”, removing all ashtrays from their environment the day before their quit date, behavioral modification, craving control, and correct use of their medication therapy.
* The pharmacist will schedule follow-up check-ins with the patient to assess effectiveness and appropriateness of the medication therapy and monitor patient progress in their quit attempt.

**Communication:**

The pharmacist prescribing the tobacco cessation medication will notify the office of the physician specified below of the medications prescribed and a summary of the patient encounter within 7 business days of dispensing the medication [See Appendix A].

This agreement is voluntary and may be terminated via written request at any time by either party. This document will be reviewed by both parties at least **[annually or insert other time frame]**.

**Signatures of Participating Physician:**

This agreement is effective as of the dates set forth below:

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This collaborative practice agreement template is for general information purposes only. The Pharmacy Society of Wisconsin assumes no responsibility for errors or omissions contained in this collaborative practice agreement template. All delegation protocols should be reviewed by each delegating physician and accepting pharmacy and pharmacist(s) before signing to ensure compliance with all state and federal laws and rules, as well as payor policies. In no event shall the Pharmacy Society of Wisconsin be liable for any damages whatsoever arising out of or in connection with the use of this collaborative practice agreement template. The information in this collaborative practice agreement template shall not be relied upon as an alternative to legal advice from an appropriately qualified professional.

**[Date]**

Dear Dr. **[Insert Name]**

This notification is to inform you that **[Insert name(s) of tobacco cessation medication dispensed to patient, strength, directions for use, and number of refills]** was prescribed and dispensed for **[Insert patient name and DOB]** for the purpose of tobacco cessation assistance as specified in our Tobacco Cessation Collaborative Practice Agreement.

The following quit plan was discussed with the patient:

**[Insert instructions/advice provided to the patient]**

**[Insert lifestyle changes discussed with the patient]**

**[Insert special concerns pertaining to the patient]**

Follow-up discussions with the patient are expected to occur on or around **[Insert dates]**.

Please feel free to contact us if you have any questions or concerns.

Respectfully,

**[Name of pharmacist(s)]**

**[Name/Contact Info of Pharmacy]**

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