

COLLABORATIVE AGREEMENT TEMPLATE

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 South Dakota Codified Law 36-11-19.1

Institution

Address

Telephone

Pharmacist Name License Number

Physician Name License Number

Pharmacist Name License Number

Physician Name License Number

Pharmacist Name License Number

Physician Name License Number

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.
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 Date

Physician Signature Date

Pharmacist Signature Date Date

Physician Signature Date

Pharmacist Signature Date Date

Physician Signature Date