## KALEIDA HEALTH PHARMACIST
COLLABORATIVE DRUG THERAPY MANAGEMENT IN NYS

### CREDENTIALS REQUIRED:

<table>
<thead>
<tr>
<th>Terminal Degree:</th>
<th>Criteria 1</th>
<th>Number of Years of Licensure &gt; or = 2</th>
<th>Must meet BOTH Criteria 1 and 2 to qualify</th>
</tr>
</thead>
<tbody>
<tr>
<td>PharmD or MS in Clinical Pharmacy</td>
<td>Criteria 2</td>
<td>Clinical Experience &gt; or = 1 year</td>
<td></td>
</tr>
</tbody>
</table>

In addition, one of the following must be met*:

<table>
<thead>
<tr>
<th>Criteria 3</th>
<th>Board Certified</th>
<th>If no must meet Criteria 4</th>
</tr>
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<tbody>
<tr>
<td>Criteria 4</td>
<td>Completion of Residency Program</td>
<td>If no must meet Criteria 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Terminal Degree:</th>
<th>Criteria 1</th>
<th>Number of Years of Licensure &gt; or = 3</th>
<th>Must meet BOTH Criteria 1 and 2 to qualify</th>
</tr>
</thead>
<tbody>
<tr>
<td>BS in Pharmacy</td>
<td>Criteria 2</td>
<td>Clinical Experience &gt; or = 1 year</td>
<td></td>
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In addition, one of the following must be met*:

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### Criteria 1: Years of Licensure MANDATORY

Current, active New York State license is required. The duration of licensure is dependent on the degree. **PharmD or MS in Clinical Pharmacy** must have minimum **2 years’ experience** as a licensed pharmacist or **BS in Pharmacy** a **minimum of 3 years’ experience** (within the last 7 years) as a licensed pharmacist is required. Licensure may be from anywhere in the US.

### Criteria 2: Clinical Experience MANDATORY

Must have a minimum **1 year of clinical experience as a licensed pharmacist.** Such experience shall be the provision of clinical services in a health facility, which involves consultation with physicians with respect to drug therapy and may include a residency at a facility involving such consultation. **Clinical services** are defined as the collection and interpretation of patient data for the purpose of initiating, modifying and monitoring drug therapy with associated accountability and responsibility for outcomes in a direct patient care setting. All clinical experience must have been gained within the 3 years preceding application for CDTM credentialing.
Criteria 3: Board Certification
Certification by an accreditation body approved by the board may be used to satisfy criteria 3. This includes, but is not limited to, certifications offered by the Board of Pharmaceutical Specialties (BPS), the Commission for Certification in Geriatric Pharmacy, the National Certification Board for Anticoagulation Providers (NCBAP) and the American Academy of HIV Medicine (AAHIVM).
Terminal certification programs, i.e. those that provide educational programming without the necessity to meet training and/or education requirements prior to an examination and do not include a recertification process, will not meet this requirement.

Criteria 4: Residency Training
Completion of an accredited or accreditation-pending residency program is required if criteria 3 is not met. In addition, if residency training is used to meet clinical experience (criteria 2) either board certification (criteria 3) or an additional year of clinical experience must be obtained to qualify.

JOB DUTIES
Collaborative drug therapy management means the performance of clinical services by a pharmacist relating to the review, evaluation and management of drug therapy to a patient, who is being treated by a physician for a specific disease or associated disease states, in accordance with a written agreement or protocol with a voluntarily participating physician and in accordance with the policies, procedures, and protocols of Kaleida Health.

(1) Adjusting or managing a drug regimen of a patient, pursuant to a patient specific order or protocol made by the patient’s physician, which may include adjusting drug strength, frequency of administration or route of administration. Adjusting the drug regimen shall not include substituting or selecting a different drug which differs from that initially prescribed by the patient’s physician unless such substitution is expressly authorized in the written order or protocol. The pharmacist shall be required to immediately document in the patient’s medical record changes made to the patient’s drug therapy and shall use any reasonable means or method established by the facility to notify the patient’s other treating physicians with whom he or she does not have a written agreement or protocol regarding such changes. The patient’s physician may prohibit, by written instruction, any adjustment or change in the patient’s drug regimen by the pharmacist;

(2) Evaluating and, only if specifically authorized by the protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering disease state laboratory tests related to the drug therapy management for the specific disease or disease state specified within the written agreement or protocol; and

(3) Only if specifically authorized by the written agreement or protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering or performing routine patient monitoring functions as may be necessary in the drug therapy management, including the collecting and reviewing of patient histories, and ordering or checking patient vital signs, including pulse, temperature, blood pressure and respiration.
ADDITONAL PROVISIONS

(1) The existence of a written agreement or protocol on collaborative drug therapy management and the patient’s right to choose to not participate in collaborative drug therapy management shall be disclosed to any patient who is eligible to receive collaborative drug therapy management. Collaborative drug therapy management shall not be utilized unless the patient or the patient’s authorized representative consents, in writing, to such management. If the patient or the patient’s authorized representative consents, it shall be noted on the patient’s medical record. If the patient or the patient’s authorized representative who consented to collaborative drug therapy management chooses to no longer participate in such management, at any time, it shall be noted in the patient’s medical record. In addition, the existence of the written agreement or protocol and the patient’s consent to such management shall be disclosed to the patient’s primary care physician and any other treating physician or healthcare provider.

(2) Participation in a written agreement or protocol authorizing collaborative drug therapy management shall be voluntary, and no patient, physician, pharmacist, or facility shall be required to participate.

PRACTICE RELATIONSHIPS

A written agreement or protocol, pursuant to and consistent with an applicable state or federal requirements, that addresses a specific disease or associated disease states and that describes the nature and scope of collaborative drug therapy management to be undertaken by the pharmacists, in collaboration with the participating physician is required.

CORE PRIVILEGES

<table>
<thead>
<tr>
<th>Privilege</th>
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<tbody>
<tr>
<td>Initiation, discontinuation and modification of a drug regimen</td>
</tr>
<tr>
<td>Order and interpret appropriate diagnostic/laboratory tests as specified in the treatment protocol</td>
</tr>
<tr>
<td>Make appropriate referrals to other health professionals and community agencies</td>
</tr>
<tr>
<td>Reassess and modify the drug regimen as necessary to achieve medical and health goals</td>
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Attach the collaborating physician agreement(s).
KALEIDA HEALTH PHARMACIST

COLLABORATIVE DRUG THERAPY MANAGEMENT IN NYS

__________________________________
_________
NAME OF PHARMACIST

THE COLLABORATING PHYSICIAN MUST COMPLETE THIS SECTION by checking one of the following:

______ a) I, as Collaborating physician, have personally observed __________________________
(applicant’s name) in the clinical setting and can attest he/she has the cognitive skills appropriate.

_______ b) I, as Collaborating physician, have not personally observed __________________________
(applicant’s name) in the clinical setting and recommend he/she be given a six (6) month provisional approval with direct supervision at the end of which an attestation as to competence will be required.

__________________________________
Practitioner’s Signature

____________________
Date

__________________________________
Collaborating Physician’s Signature

____________________
Date

Collaborating Physician’s Name (Print)

__________________________________
Collaborating Physician’s Department/Division

__________________________________
Department Chief of Service Signature

____________________
Date

__________________________________
Advanced Practice Provider Committee

____________________
Date