Washington State Department of Health

Pharmacy Quality Assurance Commission
P.O. Box 47877
Olympia WA, 98504-7877
360-236-4700
Fax: 360-236-4918

Collaborative Drug Therapy Agreement Process

WAC 246-945-350

1. A Collaborative Drug Therapy Agreement (CDTA) is permitted to include a single pharmacist or a group of pharmacists exercising prescriptive authority under the delegation of a practitioner authorized to prescribe.
   a. The authorizing prescriber shall determine the appropriate number of pharmacists authorized to prescribe under the prescriber's authority.
   b. The authorizing prescriber shall determine the scope of practice delegated and shall set any limitations of the prescribing that has been delegated.
2. A CDTA shall be filed with the Pharmacy Quality Assurance Commission (PQAC). The signature of the prescriber must be dated after all pharmacist(s) have signed and dated the agreement. Signatures may be wet or electronic in nature. CDTAs must be submitted in one of the following formats:
   a. A document listing a single prescriber and a single pharmacist with both parties' signatures,
   or
   b. A document listing a single prescriber and multiple pharmacists with the prescriber and multiple pharmacists' signatures.
3. Upon filing of the CDTA with the PQAC each pharmacist will be assigned a unique CDTA identifier.
4. A CDTA:
   a. Shall be continually updated to reflect all current pharmacist(s) covered by the agreement.

      This includes both additions and deletions of pharmacist(s). A change in the authorizing prescriber will require a new CDTA be filed.

Note: When multiple prescribers have signed the CDTA:

   a. A change in one or more of the authorizing prescribers does not require a new CDTA as long as at least one of the other authorizing prescribers is continuing to authorize the prescription authority delegated in the CDTA.
   b. A new CDTA shall be required if there is a change in scope of the delegation, whether by amendment from the authorizing prescriber or by removal of an authorizing prescriber who had delegated specific (qualified or limited) prescription authority and no other authorizing prescriber on the CDTA is delegating the specific prescription authority to the pharmacist(s) in the CDTA.

    c. A new pharmacist may be added to the agreement during the two-year period the agreement is on file by submitting to the PQAC a document signed by the authorizing prescriber and the pharmacist and a copy of the CDTA previously filed.
    d. The addition or deletion of a pharmacist(s) does not extend the PQAC's assigned expiration date.

5. Employers may facilitate the filing and management of a CDTA on behalf of a pharmacist(s) and prescriber however;
    a. A CDTA is an agreement between a pharmacist and a prescriber.
    b. It is not an agreement between a corporation or an employer and a prescriber.
    c. Employers may not restrict or impose limitations on communication between the pharmacist(s) and the authorizing prescriber.
6. When a CDTA is facilitated by an employer:
    a. The employer may coordinate the QA program or systems that support **WAC 246-945-350** used to provide the authorizing prescriber with documentation of decisions, communication and feedback.
    b. An employer through policy may limit the implementation of a pharmacist's CDTA within the employer's setting.

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Collaborative Drug Therapy Agreement Review Form

WAC 246-945-350

Please Note: This form must be completed fully. Failure to do so may result in a delay of processing. Mail this form and the signed agreement to the address above or to HSQAFacilitiesCredentialing@doh.wa.gov.

Date	Agreement: ☐ New ☐ Renewal, credential # PHCT.PH ____________		
Name/Type of Agreement (Immunization, etc.):			
Effective Date of Agreement: (Same as date signed by prescriber)	Date Agreement Expires: (Two years or less from the effective date)		
Pharmacist's Name (please print):	Pharmacist's Credential Number: PHRM.PH. ____________		
Mailing Address:			
City:	State:	Zip Code:	
Email Address:			
Practice Site Facility Name:	Phone (enter 10 digit #):		
Practice Site Facility Address:			
City:	State:	Zip Code:	
Authorizing Prescriber's Name (please print):	Prescriber's Credential Number:		
Mailing Address:			
City:	State:	Zip Code:	
Email Address:			

	Applicant	Staff	Comments
1. The agreement includes a signed statement delegating prescriptive authority to named pharmacist(s).			
2. The agreement lists by name and license number all of the pharmacists that are party to the agreement and includes a signature by each pharmacist named in the agreement to verify acceptance of delegation.			
3. The agreement designates a time frame for the agreement, not to exceed two years.			
4. The delegating prescriber(s) signed the agreement.			
5. The agreement specifies which patients are eligible to receive services under the agreement.			
6. Delegated prescribing activities are specified (disease, drugs, categories) in the agreement.			
7. Does agreement include controlled substances? Yes or No			
8. The agreement includes a plan for prescriber feedback and quality assurance.			
9. The agreement includes a plan or guideline for making prescribing decisions.			
10. The agreement includes procedures for documenting prescribing decisions.			
11. The agreement includes copies of any/all forms to be used in association with the agreement.			
12. The agreement includes a description of any training the pharmacist must complete to include specialized training required for immunizations.			

For Official Use Only

Comments:

Reviewer: ____ Date review completed: ______________________