Save Print Reset

STATE OF MISSOURI
MISSOURI BOARD OF PHARMACY

PHARMACIST APPLICATION FOR A CERTIFICATE OF MEDICATION THERAPEUTIC PLAN AUTHORITY

$50 APPLICATION FEE IS NON-REFUNDABLE

MAILING ADDRESS:
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102
(573) 751-0091
(573) 526-3464 (FAX)

DELIVERY ADDRESS:
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

SECTION I - GENERAL INFORMATION

PHARMACIST NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	E-MAIL ADDRESS		
MISSOURI PHARMACIST LICENSE NUMBER (APPLICANTS MUST HOLD A CURRENT AND ACTIVE MISSOURI PHARMACIST LICENSE)	☐ Check here if you have a Missouri pharmacist license application currently pending with the Board. A certificate of medication therapeutic plan authority will not be granted until your Missouri pharmacist license is ISSUED. Application fees will not be refunded if your pharmacist license is not issued/approved.		

SECTION II - QUALIFICATIONS

Pursuant to 20 CSR 2220-6.060, applicants must have completed ONE of the following to qualify for a Certificate of Medication Therapeutic Plan Authority:

1. A doctor of pharmacy degree (PharmD) earned from a school accredited by the Accreditation Council for Pharmacy Education (ACPE), or
2. A post-graduate medication therapy certificate course or program accredited or granted by the ACPE, American Society of Health-System Pharmacists, American Society of Consultant Pharmacists or the American Pharmacists Association, or
3. A current certification from the Board of Pharmaceutical Specialties, the Commission for Certification in Geriatric Pharmacy, or the National Certification Board for Diabetes Educators, or
4. A post-graduate medication therapy certificate course that complies with 20 CSR 2220-6.070.

Applicant hereby states that he/she has satisfied one of the following: (SELECT ONLY ONE OF THE QUALIFIERS BELOW; Do not select multiple qualifiers.)

☐ **QUALIFIER #1 - PHARM D. –** I hold a doctor of pharmacy degree (PharmD) earned from a school accredited by the Accreditation Council for Pharmacy Education (ACPE). *If checked, complete next line then go to* ***Section III****.*

SCHOOL OF PHARMACY	DATE OF GRADUATION	DEGREE EARNED

☐ **QUALIFIER #2 - ACCREDITED PROGRAM –** I have successfully completed a post-graduate medication therapy certificate course or program accredited or granted by the:

☐ ACPE
☐ American Society of Health-System Pharmacists
☐ American Society of Consultant Pharmacists
☐ American Pharmacists Association

(Proof of completion/certification MUST be attached. If checked, complete next two lines then go to ***Section III****.*

COURSE/PROGRAM NAME	DATE COMPLETED
COURSE PROVIDED BY	

☐ **QUALIFIER #3 - CERTIFICATE PROGRAM –** I hold a current certification from the:

☐ Board of Pharmaceutical Specialties
☐ Commission for Certification in Geriatric Pharmacy
☐ National Certification Board for Diabetes Educators

(Proof of certification MUST be attached. If checked, complete next line then go to ***Section III****)*

DATE CERTIFICATION ISSUED	IS THE CERTIFICATION CURRENT?
	☐ YES ☐ NO

☐ **QUALIFIER #4 - ALTERNATIVE COURSE –** I have successfully completed a post-graduate medication therapy certificate course or program that meets the requirements of 20 CSR 2220-6.060(2). *Complete questions 1-14 below then go to Section III.*

CERTIFICATE COURSE/PROGRAM PROVIDER	DATE COURSE/PROGRAM COMPLETED

NAME OF COURSE/PROGRAM

DID YOU RECEIVE A MEDICATION THERAPY CERTIFICATE? *IF YES, PROOF OF CERTIFICATION MUST BE ATTACHED*
☐ YES ☐ NO

ONLY ANSWER QUESTIONS 1-14 BELOW AND SUBMIT DOCUMENTATION IF YOU CHECKED #4 AS A QUALIFIER.

Pursuant to 20 CSR 2220-6.060, medication therapy certificate courses/programs must include training/instruction in each of the areas listed below. Applicants are responsible for submitting sufficient proof of compliance with this application.

1.	Assessing patient specific data and issues	☐ YES ☐ NO
2.	Establishing medication therapeutic goals or medication related action plans for identified medication conditions and medication related concerns	☐ YES ☐ NO
3.	Assessing and addressing adverse reactions and adverse drug events	☐ YES ☐ NO
4.	Modifying and monitoring medication regimens	☐ YES ☐ NO
5.	Improving patient care and outcomes through medication therapy services	☐ YES ☐ NO
6.	Evaluating treatment progress	☐ YES ☐ NO
7.	Assessing and monitoring pharmacokinetic and pharmacodynamic changes in medication regimen reviews	☐ YES ☐ NO
8.	Medication reconciliation	☐ YES ☐ NO
9.	Drug utilization review	☐ YES ☐ NO
10.	Applicable state or federal law	☐ YES ☐ NO
11.	Formulating and documenting personal medication records	☐ YES ☐ NO
12.	Documenting clinical outcomes	☐ YES ☐ NO
13.	Interpreting, monitoring, ordering, and accessing patient test results	☐ YES ☐ NO
14.	Patient education and counseling	☐ YES ☐ NO

SECTION III - ATTESTATIONS

1.	I understand that I may only provide medication therapy services pursuant to a written protocol with a Missouri licensed physician that complies with 20 CSR 2220-6.080.	☐ YES ☐ NO
2.	I understand that I am prohibited under 20 CSR 2220-6.070 and 20 CSR 2220-6.080 from initiating or modifying any controlled substance therapy.	☐ YES ☐ NO

By my signature below, I hereby attest that I have personally completed the foregoing application knowingly, truthfully and completely, without ommissions. All the information and answers contained in the foregoing application and any attachments hereto are true and correct to my best knowledge and belief. I understand that any false statement or material omission may result in discipline or further penalty under state law. I further understand that I must comply with all federal and state laws as well as the rules and regulations of the Missouri Board of Pharmacy. I am aware that all medication therapy services must be provided in accordance with, and pursuant to, a protocol with a Missouri licensed physician that complies with 20 CSR 2220-6.080. I hereby certify under the penalty of perjury that the above statements, as well as all information provided here, are true and correct.

PHARMACIST SIGNATURE	DATE