Example A

Administration of Immunizations

Pharmacists Prescriptive Authority Protocol

Purpose
As health care’s most accessible practitioner, the pharmacist has a unique opportunity to advocate public health initiatives. Using this protocol, pharmacists will utilize their unique access to patients and their knowledge and skills to prescribe and administer immunizations. Low rates of immunizations have supported a federal mandate to increase coverage and a national task force has recommended the expansion of administration of vaccines.

Procedures and Protocols
Training: Prior to beginning an immunization program, each pharmacist will successfully complete a training and certification program that teaches the current guidelines and recommendations of the Academy on Immunization Practices (American Academy of Pediatrics and the American Academy of Family Physicians) and the Standards for Pediatric Immunization Practice. This will include appropriate demonstrations of immunization-related patient management skills (e.g. injections, record keeping and medical screening).

Procedures: Procedures utilized for immunizations will comply with the Standards for Immunization Practice recommended by the National Vaccine Advisory Committee and approved by the US Public Health Service and other organizations. Many of these, such as patient education, patient referral and advice for follow-up are already common practices for pharmacists. The pharmacist also agrees to comply with the recommendations in the Washington State Pharmacists Quality Assurance Plan for Collaborative Drug Therapy Agreements.

Review: Each quarter the pharmacist will provide a summary of immunizations provided to the authorizing physician. The authorizing physician will be notified of individual cases of question or concern as they occur. The authorizing physician will review these with the pharmacist and take appropriate action.

Vaccines to be administered
Diphtheria, tetanus and acellular pertussis (DtaP)
Hepatitis B
Hepatitis A
Influenza
Pneumococcal
Other vaccines and biologic agents as mutually agreed
The recommendation of the Advisory Committee on Immunization Practices (ACIP) and those of the Committee on Infectious Diseases (Red Book) will be utilized in the administration of vaccines.
Guidelines for Prescriptive Authority Decisions
The Pharmacist will follow algorithms for the administration of the immunizations. A patient history will be taken and the pharmacist will consult with previous medical providers as appropriate.

Documentation
Each pharmacist will document all immunizations as required by the stature. All immunizations should also be recorded on the individual’s personal immunization card or an immunization record provided to the patient. If the patient has a regular health care provider in the community the pharmacist will provide the immunization record to that provider. A standard form will maintain a patient record of administration.

Protocol Review
This protocol requires the Authorizing Prescriber to review periodically the activities of the pharmacists providing and administering immunizations and to provide feedback to the pharmacists when deemed necessary.

Authorizing Prescriber Statement

_________________ Pharmacists (______, Washington)
and __________________, M.D.

ADMINISTRATION OF IMMUNIZATIONS
PHARMACIST PRESCRIPTIVE AUTHORITY PROTOCOL

AUTHORIZING PRESCRIBER STATEMENT:

I, ________________, M.D. licensed in the State of Washington, do hereby authorize ____________, R.Ph. at ____________ and other certified pharmacists employed at ____________ Pharmacies, to prescribe and administer immunizations to patients in accordance with the laws (RCW 18.64.011) and regulations (WAC 246-863-100) of the State of Washington. In exercising this authority the pharmacists shall comply with the protocol Administration of Immunizations.

This authorization will be in effect for two years unless rescinded earlier in writing to the Washington State Board of Pharmacy by either party. Any significant changes in the protocol must be agreed upon by the participants and submitted to the board.

Date: ______________

Physician Signature: __________________________ License #: __________________

Date: ______________

Pharmacist Signature: __________________________ License #: __________________