

Applicant's Name: _____	Completed by: _____	Date: _____
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**PHARMACY SUPPLEMENTAL APPLICATION**

Number of Pharmacists: _____	Number of Pharmacy Technicians: _____
Prior Year Prescriptions: _____	Projected Number of Prescriptions: _____
<ol style="list-style-type: none"> <li>1. Do you provide mail order or internet pharmacy services. If 'Yes', please explain in the Comments Section. <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>2. Do you provide services to healthcare facilities? If 'Yes', please explain in the Comments Section. Include related revenues. <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>3. Are you a member of the Institute for Safe Medication Practices (ISMP)? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>4. Before a drug is dispensed, do you always require and verify the following patient information:               <ol style="list-style-type: none"> <li>a. Patient's identifiers (name, address, date of birth, etc.) <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>b. Drug history (including herbals, dietary supplements, etc.) <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>c. Allergies, and other chronic conditions as well as medical history <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> </ol> </li> <li>5. Are telephone orders only taken by a pharmacist from authorized professional staff and repeated back to the prescriber for verification? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>6. Are products with known look-alike drug names stored separately and not alphabetically? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>7. Are pharmacists and technicians trained in the procedure for responding to a serious medication error which includes immediate:               <ol style="list-style-type: none"> <li>a. Disclosure to patient <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>b. Notifying the prescribing practitioner <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> </ol> </li> <li>8. Do you have access to drug information (i.e., Drug Facts and Comparisons, Micromedex, etc.)? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>9. Does the computer system perform pediatric dose range checks? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>10. Does the computer system detect drug contraindications, interactions, duplications against medical history and other prescribed drugs? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>11. Are special alerts built into the system concerning problematic or look-alike drug names, packaging, or labeling? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>12. Are criteria established (i.e., targeted high-alert drugs, patient population) to trigger required medication counseling (i.e., alert tag on bag)? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> <li>13. Are all prescriptions dispensed with current written instructions? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></li> </ol>	

**Comments Section:**

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