Application for HIV Postexposure Prophylaxis Certification

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258
Website: https://floridaspharmacy.gov/
Email: info@floridaspharmacy.gov
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DH5098-MQA, 6/2024, Rule 64B16-31.010, F.A.C.

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All applicants must hold a current Florida Pharmacist license that is active and in good standing.

HIV Postexposure Prophylaxis Certification

Prior to providing services under a collaborative pharmacy practice agreement, a pharmacist must be certified by the board. Additionally, a pharmacist may order and dispense HIV postexposure prophylaxis drugs pursuant to a written collaborative practice agreement between the pharmacist and a physician licensed under chapter (ch.) 458 or ch. 459, Florida Statutes. Refer to section 465.1861, Florida Statutes, prior to submitting your application.

Postexposure prophylaxis means a drug or drug combination that meets the clinical eligibility recommendations of the United States Centers for Disease Control and Prevention guidelines for antiretroviral treatment following potential exposure to HIV.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and official correspondence will be sent.)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box – this address will be posted on the Department of Health's website.)

_____ _____ _____
Street Apt. No. City

_____ _____ _____ _____
State ZIP Country Business Telephone

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. LICENSURE HISTORY

What is your Florida Pharmacist (PS) license number? _____

Name: _____

3. CERTIFICATION TRAINING

To qualify for certification, the pharmacist must have completed a certification course that meets the requirements of section 465.1861, Florida Statutes, and Rule 64B16-31.010, Florida Administrative Code (F.A.C.).

Have you successfully completed a course approved by the Florida Board of Pharmacy? Yes No

If "Yes," provide the following information.

Provider Name	Provider Number	Date of Completion (MM/DD/YYYY)	Certificate Number

Provide a copy of the certificate of completion.

4. APPLICANT BACKGROUND

To qualify for this certification, the pharmacist must be engaged in the active practice of pharmacy and have earned a degree of doctor of pharmacy or have completed at least three years of experience as a licensed pharmacist.

A. Are you engaged in the active practice of pharmacy? Yes No

B. Have you earned a degree of doctor of pharmacy? Yes No

If "Yes," list the name of the university, college, or school of pharmacy you attended.

School Name	City/State or Country	Graduation Date (MM/DD/YYYY)	Degree Awarded

C. Have you completed at least three years of experience as a licensed pharmacist? Yes No

If "Yes," list your experience below.

Employer	Address of Employment	Employment Dates: From-To (MM/DD/YYYY)
		to
		to
		to

5. PROFESSIONAL LIABILITY INSURANCE

To provide services under a collaborative practice agreement, a pharmacist must maintain at least $250,000 of professional liability insurance coverage. A pharmacist who maintains professional liability insurance coverage as a requirement of the Test and Treat Certification or the Collaborative Practice Certification, pursuant to section 465.1895, Florida Statutes, or section 465.1865, Florida Statutes, satisfies this requirement.

Do you maintain at least $250,000 of professional liability insurance? Yes No

If "Yes," provide the following information:

Insurance Provider Name	Policy Number	Policy Expiration Date (MM/DD/YYYY)

Name: _____

6. ACCESS-TO-CARE PLAN

A pharmacy in which a pharmacist is providing services under a written collaborative practice agreement must submit an access-to-care plan to the board and department annually, pursuant to section 465.1861, Florida Statutes.

If available, provide the information below for the pharmacy(ies) in which you are providing services under a written collaborative practice agreement where the pharmacy has established an access-to-care plan in compliance with s. 456.1861(7), Florida Statutes.

Pharmacy Name	Pharmacy License #

Any pharmacy in which a pharmacist is ordering and dispensing any HIV postexposure prophylaxis drugs pursuant to s. 468.1861, Florida Statutes, must submit an access-to-care plan complying with s. 465.1861(7), Florida Statutes, to the board and department prior to any pharmacist providing services at that location.

7. COLLABORATING PHYSICIAN

If available, provide the following information for the physician licensed under ch. 458 or 459, Florida Statutes, with whom you have entered into a collaborative practice agreement.

Physician Name: _____

Physician License #: _____

COLLABORATIVE PRACTICE AGREEMENT INFORMATION

Section 465.1861(4), Florida Statutes, provides that a pharmacist who is certified by the board may order and dispense HIV postexposure prophylaxis drugs pursuant to a written collaborative practice agreement between the pharmacist and a physician licensed under ch. 458 or ch. 459.

The collaborative practice agreement must include the following information:

1. Terms and conditions relating to the screening for HIV and the ordering and dispensing of HIV postexposure prophylaxis drugs by the pharmacist. Such terms and conditions must be appropriate for the pharmacist's training.
2. Specific categories of patients the pharmacist is authorized to screen for HIV and for whom the pharmacist may order and dispense HIV postexposure prophylaxis drugs.
3. A requirement that the pharmacist maintain records for any HIV postexposure prophylaxis drugs ordered and dispensed under the collaborative practice agreement.
4. The physician's instructions for obtaining relevant patient medical history for the purpose of identifying disqualifying health conditions, adverse reactions, and contraindications to the use of HIV postexposure prophylaxis drugs.
5. A process and schedule for the physician to review the pharmacist's records and actions under the practice agreement.
6. Evidence of the pharmacist's current certification by the board pursuant to section 465.1861(6), Florida Statutes.

A physician who has entered into a written collaborative practice agreement pursuant to section 465.1861, Florida Statutes, is responsible for reviewing the pharmacist's records and actions to ensure compliance with the agreement.

A pharmacist who enters into a collaborative practice agreement must submit a copy of the signed collaborative practice agreement to the board.

Name: _____

8. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for certification in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____

You may print out this application and sign it or sign it digitally. MM/DD/YYYY

Documentation must be sent to the board office at info@floridaspharmacy.gov, or mailed to:

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