Alberta College of Pharmacy

Guide to receiving additional prescribing authorization

Updated January 2025

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Introduction

Pharmacists in good standing on the clinical register may apply for additional prescribing authorization after meeting the following criteria:

1. You must have at least one year of full-time experience in direct patient care while on the clinical pharmacist register.
    a) Entry-level Pharm D graduates from CCAPP accredited Canadian schools of pharmacy have the one-year practice requirement waived. However applicants must use patient cases from their time on the clinical pharmacist register (i.e., not as students, interns).
2. You must have strong collaborative relationships with other regulated health professionals.
3. You must have and maintain the necessary knowledge, skills and attitudes, and clinical judgement to enhance patient care.
4. You must have the required supports in your practice (e.g., access to information, communication, documentation processes) to enable safe and effective management of drug therapy.

ACP has developed this guide and four tools to assist pharmacists with researching, planning, and compiling evidence in preparation for submitting their application for additional prescribing authorization. The guide will introduce the tools which are provided to help pharmacists evaluate their preparedness for authorization and will clarify the kind of evidence assessors need to see. The tools include

- a self-assessment form,
- a case narrative form,
- a case checklist, and
- a Q&A resource.

Using these tools will help you to answer the questions in the application form and to compile the case evidence needed to prepare an application for assessment.

Overview of the process

To obtain additional authorization to initiate and manage drug therapy, pharmacists must demonstrate their ability to practise and document according to the Standards of Practice for Pharmacists and Pharmacy Technicians. They must submit a comprehensive application package that includes actual evidence of the care they provide.

Applications are evaluated by a minimum of two pharmacists who are trained to use an **objective criterion-referenced assessment tool**. It may take up to 10 weeks to process applications depending on volume. Results are sent by email. Applicants will be advised whether or not their application met the standard, and will be provided with feedback from assessors. Those who meet the standard will receive authorization from the registrar to prescribe Schedule 1 drugs in accordance with sections 45(2) and (3) of the Health Professions Restricted Activity Regulation.

Pharmacists who receive authorization **must** log in to myACP and **confirm** authorization on their digital practice permit prior to prescribing to manage or initiate drug therapy. Authorization does not expire. Renewal is automatic with the renewal of a practice permit, assuming all other permit renewal requirements are met.

Step 1: Self-assessment – is your practice ready?

The first step in the application process is to complete the self-assessment form.

The self-assessment form lists the criteria assessors will use. This tool groups a prescriber's responsibilities into six key activities and further defines the specific indicators that assessors will be looking for and rating. Each indicator is rooted in the Standards of Practice; collectively, they outline what is required of a pharmacist when providing care to a patient, especially when that care may include prescribing Schedule 1 drugs to manage or initiate drug therapy.

The self-assessment form is a tool for you to thoughtfully and honestly assess your own performance and practice. There are four preparedness questions for each of the six key activities. Take time to answer "yes" or "no" to each question. This will help you identify any gaps in your practice that need to be addressed before submitting your application. If you answer "no" to any question, the last column gives you an opportunity to develop an action plan to enhance your knowledge and/or skills in that area.

The self-assessment form is for your own use and information. **Do not** send it to the college with your application. This tool allows you to assess yourself and your practice using the same criteria that assessors will use. Resist the urge to skip this step. Even though it will not become a formal part of the application package, it is an important building block that will not only improve the quality of your submission, but will also affirm to you that you are practising in accordance with the standards. It may also help you target competencies for future personal and practice growth.

Once you have completed the self assessment form and have addressed any gaps or limitations in your practice, you are ready to complete the application.

Step 2: Assembling your application

An application is comprised of an application form and three actual **patient cases** taken from your practice to demonstrate the care you provided to three different patients.

Part A - Application form

Demographics and current practice setting

The information requested in this section is used administratively to verify eligibility, to communicate with you, and for aggregate reporting purposes. It does not factor into the assessors' evaluation of your application.

- **Section 1 - Your practice**
    - The answers that you provide in this section will give assessors a frame of reference to understand the three cases that you submit. If in your practice you use standard forms or templates, you may include samples with your descriptions. Keep in mind that the assessors do not know you or your practice; the information you provide in this section will set the stage for how they assess your work. Be as specific and concise as possible in your descriptions. If you require more space to respond to questions than has been provided, attach additional pages to the end of the application form with the necessary direction to assessors and page number (e.g., continued on page).
- **Section 2 - Your preparedness**
    - Completion of the self-assessment form will help you answer the questions found in this section. Assessors will be looking for evidence that you assess your own personal knowledge, skills, and attitudes, as well as the effectiveness of your practice. They will be looking for evidence that you regularly enhance your knowledge and skills for the benefit of your patients and your practice, and that you have a responsive means of adapting your practice when and where you feel it is needed.
    - From your self-assessment, if you feel your practice is ready for the prescribing authorization, concentrate your response in this section on how and why you are already prepared.
- **Section 3 - Your judgement**
    - Pharmacists who have been granted additional prescribing authorization indicate that they often come across situations where they must consider prescribing for a patient or for a condition that they are less familiar with, or for a condition they had not anticipated. This section of the application asks you to demonstrate how you will deal with situations such as these. The use of examples from your own practice, and a thoughtful explanation of the principles that guide you when determining your course of action, is the focus of this section. What are your boundaries?

Part B - Patient cases

The cases that you submit will provide the strongest evidence of your preparedness for additional prescribing authorization. This evidence of your work will be reviewed and assessed carefully against the same checklist of key activities and indicators provided to you in the self-assessment form. Take time to select cases for submission that are the best demonstrations of your practice.

You must submit **three actual patient cases** as part of your application. They must not be created or developed for the purpose of the application, but must be a compilation of actual notes and records of your care. Only cases that demonstrate you providing care within the last **two years** may be submitted and each case must show your assessment, collaboration, care plan development, implementation, monitoring, and follow-up.

You must preface each case with a narrative that will set the stage. The narrative is described in more detail in the next section. Together, the **record of care** and case narrative must provide sufficient evidence of all key activities and indicators listed on the self-assessment form. Once you have compiled the evidence for each case, use the case checklist to ensure that you can see evidence of the indicators being fulfilled within the pages you intend to submit. The case checklist outlines which indicators **must be evidenced in the actual patient record** and not simply explained in the case narrative.

Evidence provided in the patient record is always the strongest evidence, but depending on your practice, some indicators (e.g., how you prioritized drug therapy problems or what steps you took to identify other health professionals who are providing care to the patient) may be described more fully, or elaborated on, within the case narrative.

After you have used the case checklist, if you think the documentation in the record of care may not adequately address or demonstrate an area or indicator, you may want to include additional sources of evidence that support your work such as copies of lab reports, fax communications with other healthcare providers, and a list of clinical references. For each case, submit all relevant supporting information. This may include, but is not limited to, the following:

- patient demographics;
- actual record of care (i.e., electronic or paper charts);
- drug profile(s);
- additional notes;
- notes regarding or describing communication with other health care providers; and/or
- notes regarding or describing communication with the patient, family, or other caregivers.

Ensure that you are providing sufficient information for assessors to clearly see that you are fulfilling all of the activities and indicators required by the standards. Remember that they do not know your practice or your patient.

Confidentiality

On all of your documents, **ensure that all patient identifiers (e.g., names, addresses, healthcare numbers, etc.) are blacked out. If patient information has not been redacted, you may be committing a privacy breach and your application will be rejected.**

While in the possession of ACP and its assessors, applications are retained with a high degree of confidentiality (in accordance with the ACP privacy policy).

Clarity

Each page in the case must be numbered (e.g., you may choose to number all documents in your first case as page A-1, A-2, A-3, second case pages as B-1, B-2, B-3, etc.). When necessary, refer to these page numbers in your narrative to draw the assessors' attention to specific pieces of evidence.

Part C - Case narratives

In each case, assessors will be looking for evidence that you document your actions and/or recommendations, including the rationale, in the patient record as per the Standards of Practice for Pharmacists and Pharmacy Technicians. Since it may be unrealistic to document all information and every option you consider in the patient record, the case narrative is your opportunity to provide assessors with additional information about the thinking that was not documented in the patient record, and why it was not documented. You may also want to expand on the rationales you did document and other information you want assessors to know. You may choose to cite references such as clinical practice guidelines, peer-reviewed journals, and summaries of evidence such as Cochrane reviews. Do not submit the actual references with your case.

Ultimately, the case narrative is designed to fill in gaps so assessors, who are not experts in your practice, can determine whether your decisions reflect best practices and/or are evidence based.

The case narrative form is to be used to provide supplemental information for assessors. Complete and place one case narrative form at the front of each case.

Step 3: Submitting your application

Prior to submitting

Before submitting your application electronically, please ensure that

- you have signed and dated the declaration on page one,
- your three patient cases are each preceded by a completed case narrative form,
- all patient identifiers are blacked out, and
- you have used the case checklist and are able to see evidence of each indicator in each case.

Please note: Incomplete packages will be placed on temporary hold. You will be notified by email of the deficiencies. The assessment will be delayed until the application package is complete.

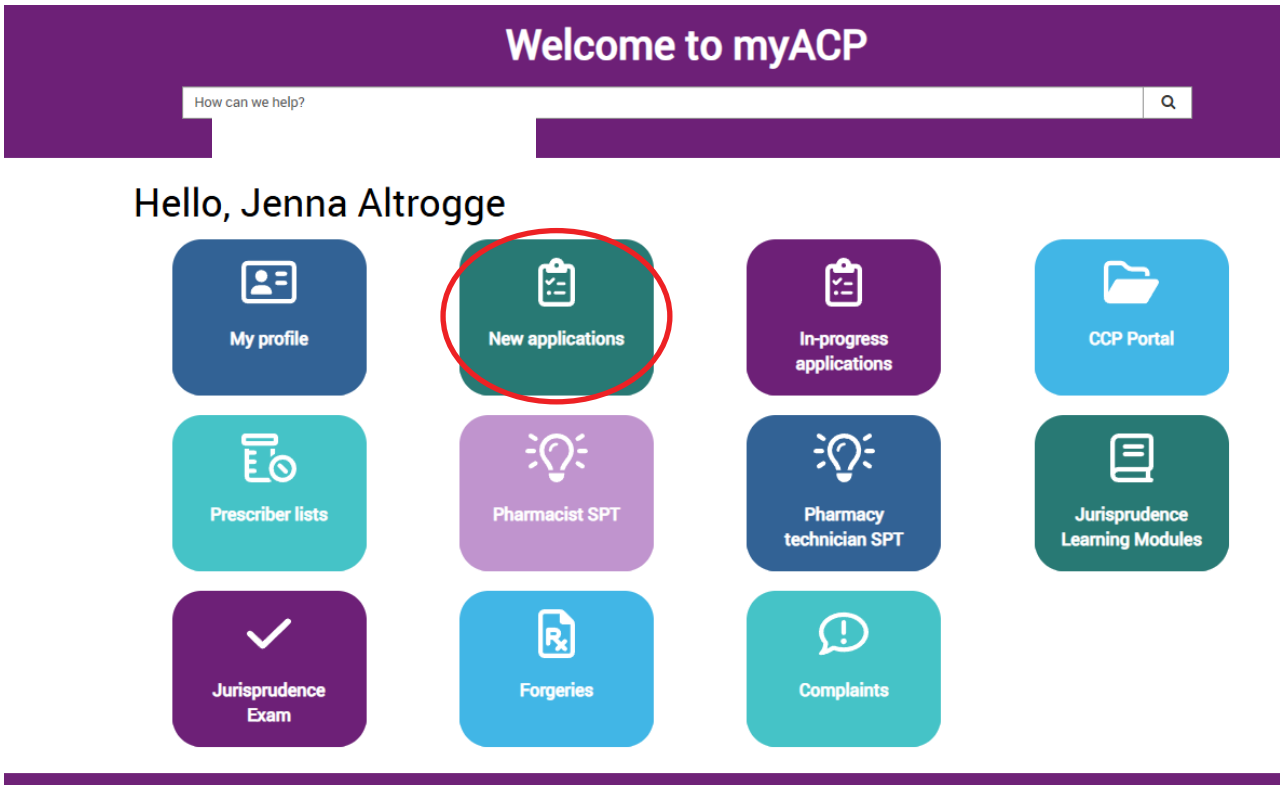
Fee for assessment

As part of your application in myACP, you will be required to submit payment. Your application cannot be processed until payment has been submitted.

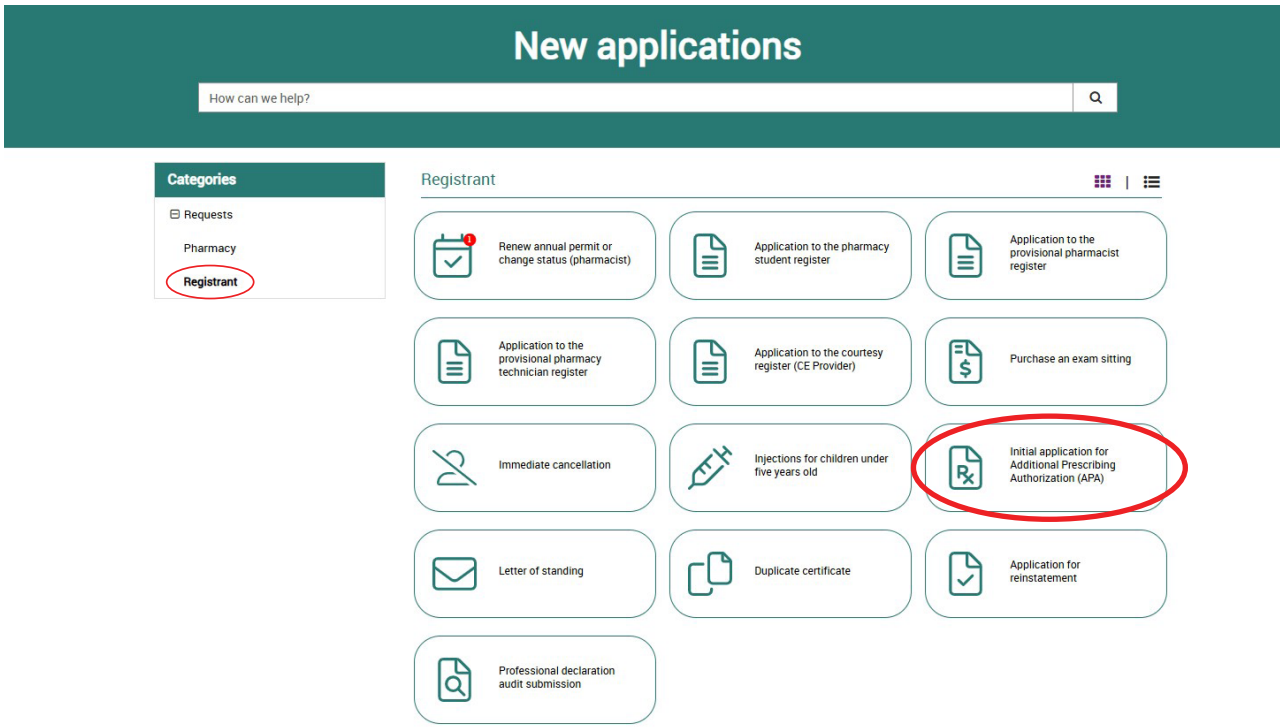
Fees can be found in ACP's fee schedule.

Submission

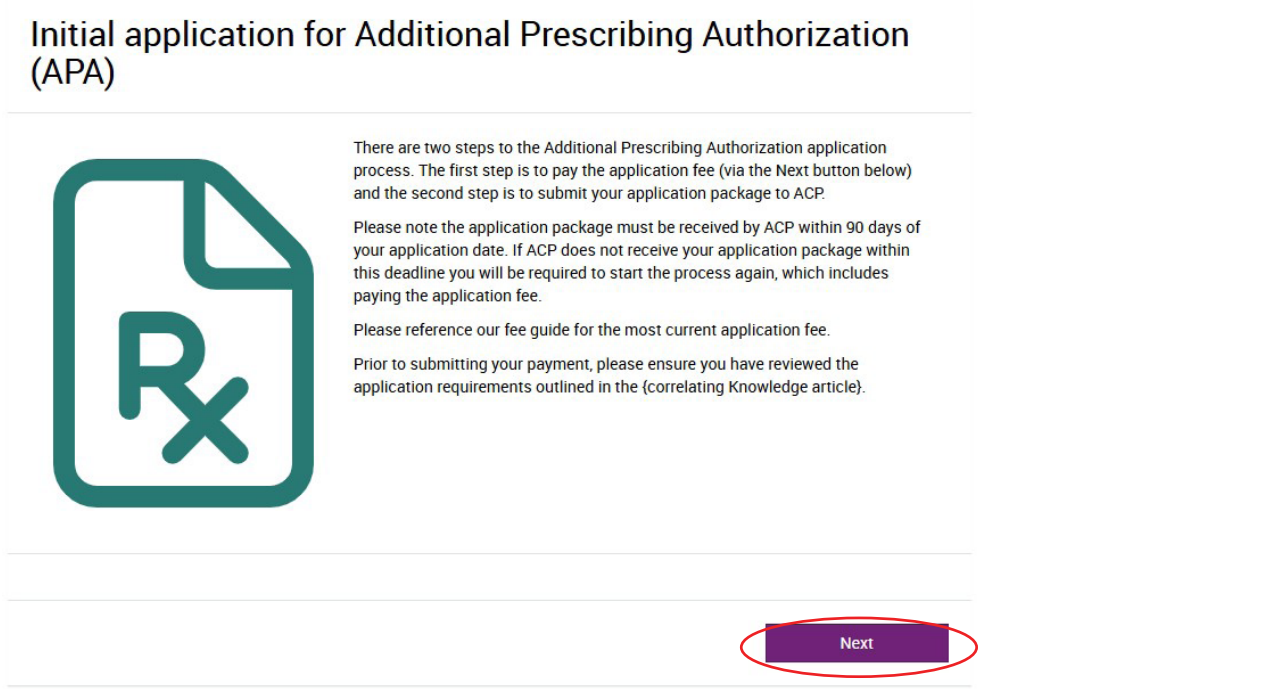
1. Log in to myACP and click on the "New applications" icon on the main page.



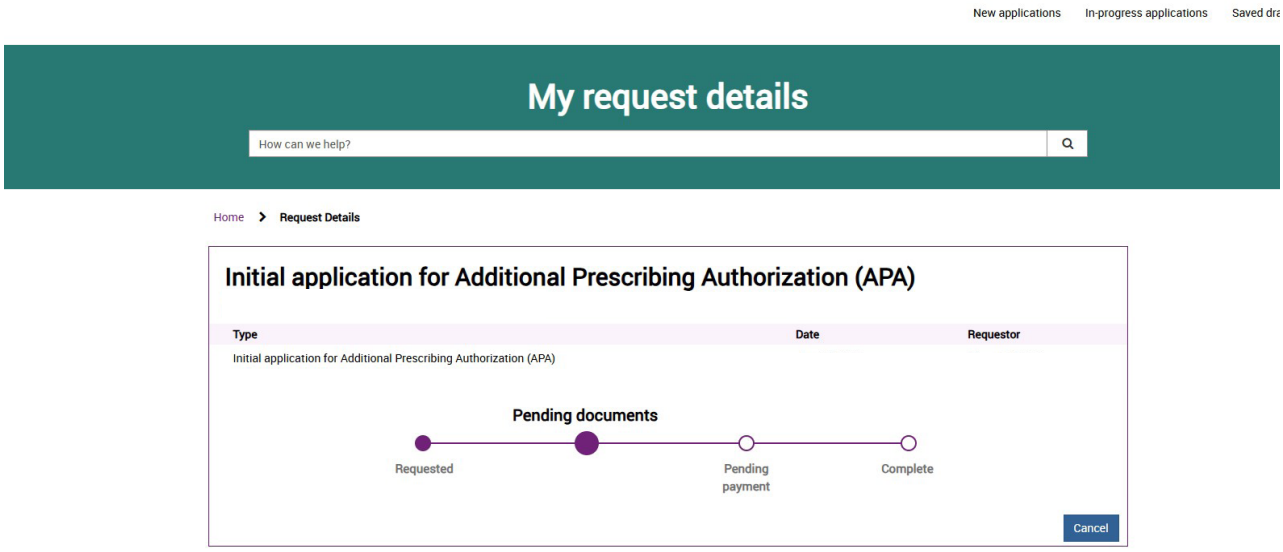
2. From the New applications menu, select the Registrant option from the left sidebar menu, then click on Initial application for additional prescribing authorization (APA).



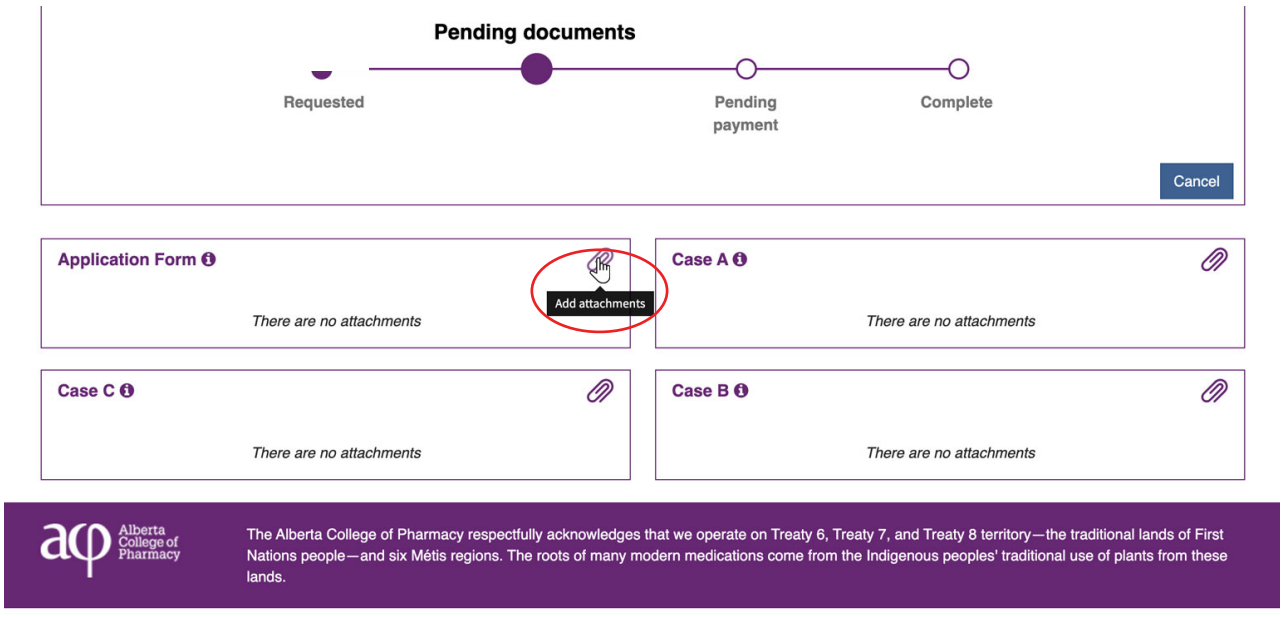
3. The application form will open. Once you are ready to proceed, click the Next button.



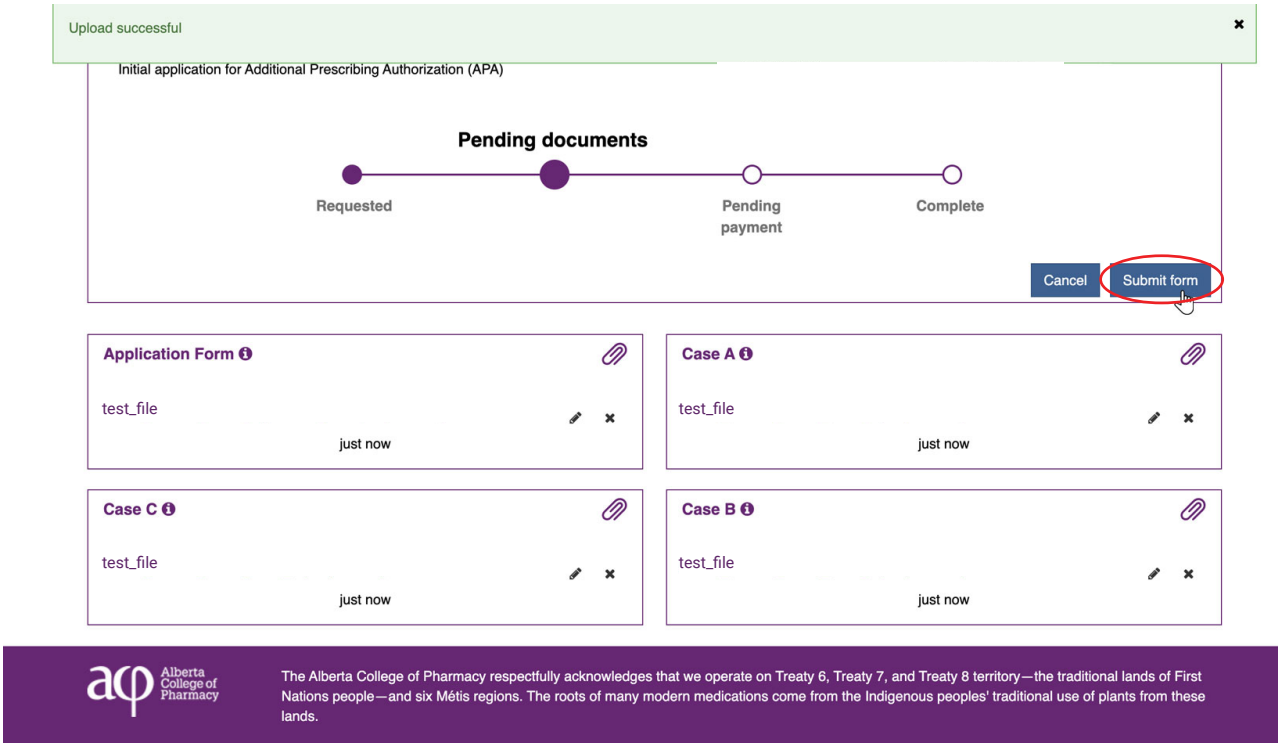
4. Complete the initial form and click Next, then the Request details screen will appear.



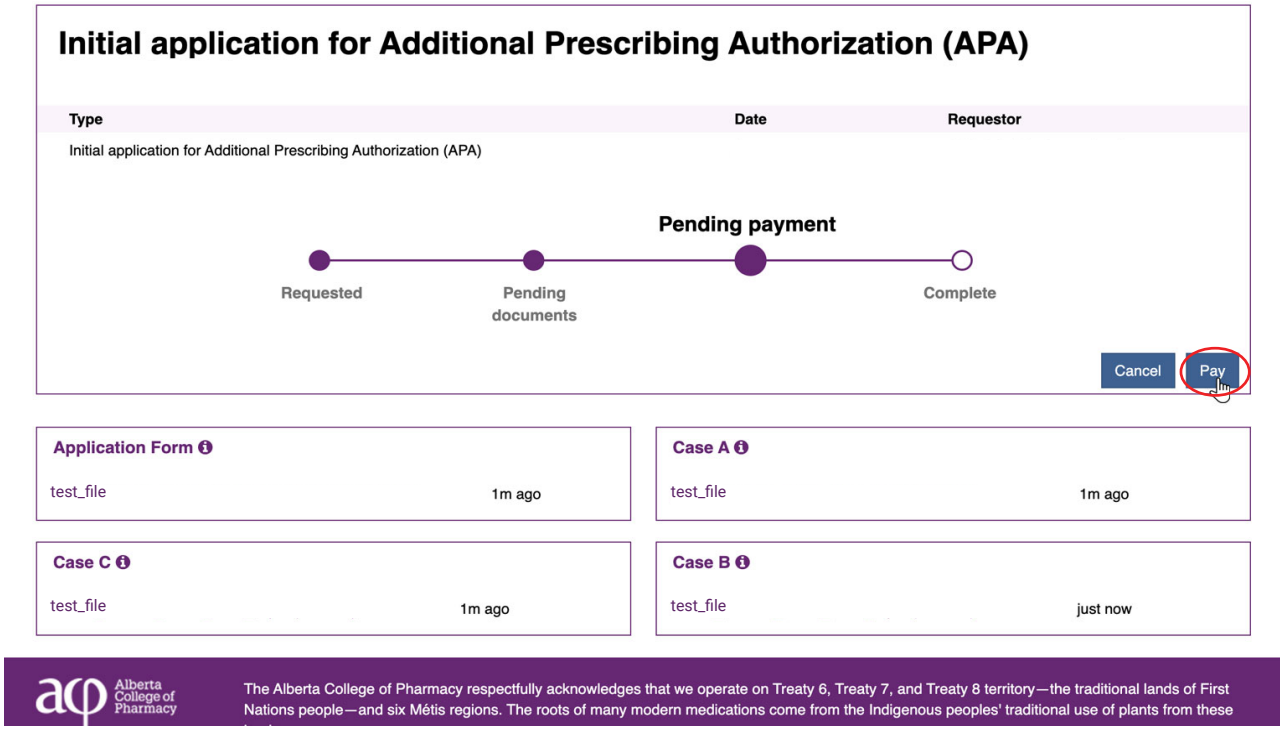
5. Scroll down to the document area and click on the paper clips to upload the required documents. I**f any of the following steps are not completed, your application will be placed on hold.**
    - All documents associated with each case narrative need to be merged/combined into **one PDF for each case file**.
    - Use the proper naming format for the files.
    - Ensure all patient information is fully masked.
    - Please refer resources, guides, and forms on the [ACP website] for assistance in completing your application.



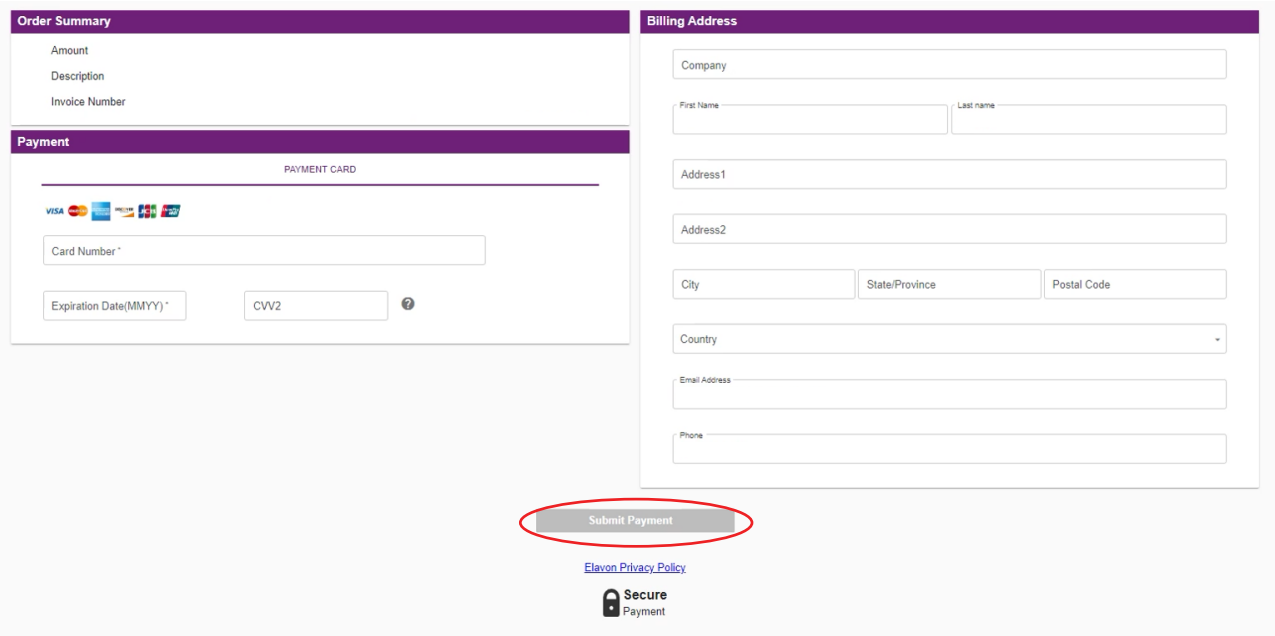
6. Once you have successfully uploaded all documents (successful uploads will be indicated by the green banner at the top of your browser window), click the Submit form button.



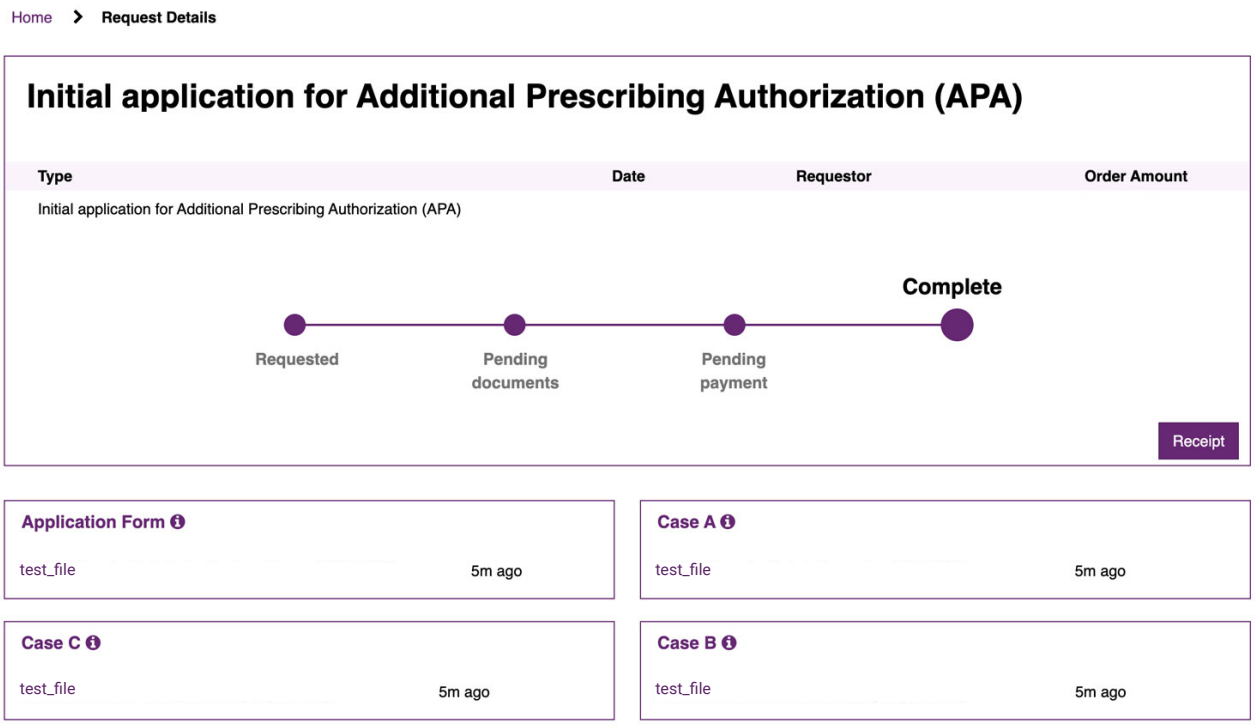
7. The progress indicator will move to Pending payment, and you can click on the Pay button.



8. The payment window will appear in a new tab. Fill out your information and click Submit payment.



9. After successfully completing payment, close the payment tab. The process will be complete and a receipt will be available by clicking on the Receipt button.



If you need further assistance, please contact us at apa@abpharmacy.ca.

Glossary

Case

For the purposes of this application, a case is the package of information you compile as evidence of the care you provided to the patient. Each case must contain copies of your documentation in the patient record and supplemental information such as notes, correspondence, and diagnostic results. In the first edition of this guide, the term “care plan” was used to denote this package of information but experience revealed that the term did not clearly convey the scope of information to be submitted. In actuality, the care plan is but one component of the case.

Objective criterion-referenced assessment

An objective criterion-referenced assessment is an evaluation of evidence based on a specific set of criteria (i.e., the key activities and indicators) used to equitably assess all applications. Measuring all applications against the same set of criteria deters subjective interpretation, holds all applicants to the same standard, and helps to ensure public safety.

Professional relationship

A professional relationship is defined in the Standards of Practice for Pharmacists and Pharmacy Technicians.

Record of care/patient record

For the purposes of this application, the record of care and patient record are synonymous and refer to your actual permanent documentation, either paper based or electronic, that contains the elements found in Appendix E of the Standards of Practice for Pharmacists and Pharmacy Technicians.

Regardless of the method of actual documentation, your patient records need to show assessors

- all relevant patient information;
- where you document your identification and prioritizing of actual and potential drug therapy problem(s) (DTPs) and what you documented;
- your documentation of your realistic, achievable goals agreed upon for each DTP selected for intervention;
- implementation of the care plan, including the monitoring plan;
- communication with other health care providers; and
- monitoring and documentation of outcomes.

Appendix A – Key activities and indicators

Form and maintain professional relationship with patient	The pharmacist identified the patient's expectations and goals of therapy.
	The pharmacist took reasonable steps to provide the patient (and/or patient's agent) with enough information to participate in the decision-making process or made it clear why this was not appropriate.
Patient assessment	The pharmacist gathered sufficient information about the patient to allow the pharmacist to work with the patient to optimize the patient's health and drug therapy.
	The pharmacist considered appropriate information to assess the patient's signs and symptoms.
	The actual and/or potential drug therapy problems were prioritized appropriately by the pharmacist.
	The pharmacist considered appropriate options to respond to drug therapy problems.
Develop care plan and follow-up	The pharmacist took appropriate action to address actual or potential drug therapy problem(s) as identified.
	The pharmacist's follow-up plan identified parameters to be monitored.
	The pharmacist's follow-up plan identified appropriate timeframes.
	The pharmacist's follow-up plan identified expected outcomes.
	The pharmacist's care plan identified who will be responsible for the monitoring.
	The follow-up plan was implemented.
Collaboration	The pharmacist identified or has taken reasonable steps to identify other health professionals who are providing care to the patient.
	The pharmacist obtained diagnostic and other relevant health information from other health professionals with the aim of determining mutual goals of therapy.
	The pharmacist communicated required information to the health professionals whose care of the patient may be affected by their recommendations/decisions.
	The pharmacist appropriately involved other health professionals in the care of the patient.
Documentation	The pharmacist documented information provided by the patient and other reliable sources in the patient record.
	The drug therapy problems (actual and/or potential) identified by the pharmacist were documented in the patient record.
	The pharmacist's care plan was documented in the patient record.
	The pharmacist documented the rationale for their recommendations/decisions in the patient record.
	The pharmacist's documentation in the patient record was adequate to facilitate ongoing care.
Judgement	The pharmacist responded appropriately based on the results of the monitoring plan.
	The pharmacist based recommendations/decision on evidence and/or best practices.