A

Model Form

for the
Development
of a
Prescribing Agreement

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An Overview of the Purpose and Extent of a Written Prescribing Agreement

Minnesota Statute, Chapter 148.235, Subdivision 4, 1999 Minnesota Session Laws specifies that an advanced practice registered nurse (APRN) must have a written prescribing agreement with a physician if the APRN wishes to prescribe medications or therapeutic devices to patients. Nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists are required, for the purposes of being delegated prescribing authority, to have a written agreement with a physician. Certified nurse midwives are not required to have a written prescribing agreement with a physician.

This document is suggested by MNA to be used as a model Prescriptive Agreement for APRNs (except for Clinical Nurse Specialists in Psychology whose prescription agreement differs slightly). This model meets the requirements of the Memorandum of Understanding. It should be noted that prescribing agreements can be drafted in any format, but must contain the minimum amount of information as determined by the standards described in the Minnesota Nurses Association (MNA) / Minnesota Medical Association (MMA) Memorandum of Understanding (MOU). Items marked with an asterisk are required to be included in the agreement.

A separate prescribing agreement must be completed, signed and maintained at the APRNs and the physician's primary practice site, and reviewed and dated at least annually. A prescribing agreement does not need to be filed with the Minnesota Board of Nursing or the Minnesota Board of Medical Practice.

Copies of the Minnesota Nurses Association (MNA) / Minnesota Medical Association (MMA) Memorandum of Understanding (MOU) may be obtained by contacting the Minnesota Board of Nursing website at www.nursingboard.state.mn.us/ or by contacting the Minnesota Nurses Association website at www.mnnurses.org.

Advanced Practice Registered Nurse Prescriptive Agreement

This prescriptive agreement must be filled out, signed and kept at the Advanced Practice Registered Nurses (APRN) place of employment per Chapter 148.235, Subdivision 4, 1999 Minnesota Session Laws "Standards for Written Agreements: Reviewing and Filing." This agreement need not be filed with the Minnesota Board of Nursing or the Minnesota Board of Medical Practice.

* 1. Physician and APRN credentials

APRN
* Name: _____
* Degrees / Certification (s) / Specialty: _____
Experience: _____

Physician
* Name: _____
* Degrees / Certification (s) / Specialty: _____
Experience: _____

* 2. Description of Patient Population to be seen by APRN

Check the boxes that describe the appropriate settings:

☐ Clinic ☐ Surgical Center ☐ Long Term Care

☐ Hospital ☐ Homecare ☐ Other (specify) _____

Patient characteristic(s):

Ages: ☐ Child ☐ Adolescent ☐ Adult ☐ Elderly

Types of conditions:

☐ All ☐ Specify: _____
_____

Physician availability for consultation and/or joint management and/or referral:
_____
_____

Expectation(s) of either party regarding communications related to patients:
_____
_____

* 3. Prescriptive Authority

In this section, indicate the categories of drugs and/or devices which may be prescribed by the APRN including any limitations to these categories. Check the box that applies to your practice.

☐ All drug categories or therapeutic devices may be prescribed as listed in the following formulary or reference: _____ (list reference here)

☐ All drug categories or therapeutic devices may be prescribed as listed in the following formulary or reference: _____ (list reference here)

With the following exceptions:_____
_____

☐ Prescriptive authority extends to the following list of drug categories:

Please make a complete list, or attach a list of drug categories to this agreement.
(NOTE: when making a list of drug categories on your own, be sure to make the list complete using a list that is accepted and known in your practice. It is important to not inadvertently exclude a category with a drug in it that you will be prescribing. If you do attempt to make your own list and there are omissions, the prescriptions that you write in this omitted category will not be legal.)

* 4. Termination or suspension of this agreement (this section must describe how the continuity of care for patients will be assured if the agreement is terminated.) _____
_____

*5. Renewal Requirement(s)

This agreement shall be officially reviewed, renewed and signed at a minimum of annually from the date of signature. We the undersigned agree to review this document on _____. By our signatures we agree to follow the parameters specified above.

APRN
* Name: _____

* Address: _____ * Phone: _____

* Signature: _____ * Date: _____

Physician
* Name: _____

* Address: _____ * Phone: _____

* Signature: _____ * Date: _____

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