

Iowa Department of Human Services
Pharmacist Eligibility Application

Instructions

Please follow these instructions to complete the application below to determine pharmacist eligibility to provide Pharmaceutical Case Management (PCM) services to Iowa Medicaid members. This application must be completed by each pharmacist interested in providing PCM services. After completing this application, please return it along with five patient care plans to PCM Application c/o Julie Kuhle, Iowa Foundation for Medical Care, 1776 West Lakes Parkway, West Des Moines, Iowa 50266. Email jkuhle@iaqio.sdps.org or fax 515-222-2411.

Pharmacists must have a license in good standing to practice pharmacy in the state where PCM services will be provided.

If this criterion is met, please indicate so by checking the appropriate box on the application form. In addition, please provide your license number and state in which you are licensed on the application form.

Pharmacists shall submit 5 (five) patient care plans as an example of their ability to identify, prevent, and resolve drug therapy problems. These care plans should also indicate the pharmacist's ability to adequately document patient care encounters. These care plans shall be recently completed, within the previous six months. Care plans will be evaluated using the Quality Assurance Tool for the Documentation of Pharmaceutical Care. This tool was developed through a grant from the APhA Foundation.

Five care plans shall be submitted along with the eligibility application. Please clearly mark each care plan with your name and check the appropriate box on the application form.

Pharmacists must also complete professional training regarding member-oriented medication-related problem prevention and resolution. The Department of Human Services approves specific professional training programs with input from a pharmacist and physician advisory committee. Acceptable programs must provide the following instruction through didactic coursework as well as practicum:

- Practice site re-engineering
- Member data collection
- Drug therapy problem identification
- Drug therapy problem prevention processes
- Clinical problem solving
- Implementation of a problem-oriented patient record
- Communication skills
- Clinical use of drug information sources

Currently the following training programs have been approved:

- Iowa Center for Pharmaceutical Care
- Doctor of Pharmacy Graduates

The Department of Human Services may consider other training programs with similar instruction and learning objectives. The applicant is required to submit evidence of the curriculum of the training program to allow adequate evaluation.

If this criterion is met, please indicate so by checking the appropriate box on the application form, and indicate which training module was completed.

Pharmacists will be asked to participate in several activities during the provision of PCM services and in support of the evaluation of PCM services. These activities include but are not limited to:

Providing PCM Services

- Encourage participation by eligible members
- Solicit physician participation in PCM services
- Submit HCFA-1500 claims
- Attend PCM training sessions

Important Note:

Some insurance (TPL) and Medicare Part D plans already cover this type of service. For Medicaid members who have TPL or Medicare Part D the provider must show that the TPL/Medicare D does not cover this service when submitting a claim to IME. Call provider services if you have any questions about how to submit a claim in such cases: 1-800-338-7909 or 515-725-1004 (local in Des Moines).

In addition, the provider is responsible for verifying any other coverage and ongoing Medicaid eligibility – Medicaid is always “payer of last resort.” If the member becomes eligible for Medicare (or other insurance) while receiving Pharmaceutical Case Management (PCM), primary coverage of the service may change. Approval for PCM service does not guarantee that coverage of the service is with Medicaid.

Supporting the Evaluation Process

- Complete an assessment of therapeutic knowledge and the drug therapy problem resolution process for research purposes
- Participate in pharmacy site visits with the research team
- Submit documentation as requested by the research team
- Utilize communication form as directed by the research team
- Communicate with research team and physicians via a timely method

If this criterion is agreed upon, please indicate so by checking the appropriate box on the application form.

If a pharmacist is seeking eligibility to provide PCM services at multiple pharmacies, an eligibility application must be completed for each pharmacy (as defined by distinct Medicaid provider number) where the pharmacist intends to provide services. However, care plan submission is only required with one application.

Please sign and date your application and print your demographic information. Submit your completed application with your five patient care plans to PCM Application, c/o Julie Kuhle, Iowa Foundation for Medical Care, 1776 West Lakes Parkway, West Des Moines, Iowa 50266 or fax 515-222-2411. Care plans may be emailed to jkuhle@iaqio.sdps.org.

Iowa Department of Human Services

Pharmacist Eligibility Application

Iowa Medicaid Pharmaceutical Case Management Program

To determine my eligibility to provide pharmaceutical care management (PCM) services for Iowa Medicaid, I submit the following information and agree to the following statements:

- I have a license in a good standing to practice pharmacy in the state where PCM services will be provided.
- Please indicate state and license number: _____
- I have submitted 5 (five) current member care plans that are representative of the care plans completed in the course of my practice.
- I have completed professional training regarding member-oriented medication-related problem prevention and resolution.
- Please indicate training module: _____
- I agree to provide PCM services to eligible Iowa Medicaid members including the activities outlined in the application instructions.
- I agree to participate in the evaluation activities as outlined in the application instructions.

I, the undersigned, hereby certify that the above statements are true.

(Signature)

(Date)

(Print Name)

(Pharmacist Name)

(Pharmacist's NPI Number Required)

(Business Address)

(City)

(State)

(Zip Code)

(Telephone)

(FAX)

(Email)