Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810
Telephone: (225) 755-7500 or (225) 755-7517
www.lsbn.state.la.us

INSTRUCTIONS FOR REQUESTING REINSTATEMENT OF PRESCRIPTIVE AUTHORITY PRIVILEGES IN LOUISIANA

INTRODUCTION

Prior to engaging in medical diagnosis and management as an Advanced Practice Registered Nurse (APRN), including writing orders and/or prescriptions, the APRN must obtain a letter of approval issued to the nurse by the Louisiana State Board of Nursing (LSBN) indicating approval for prescriptive authority (PA) privileges in the State of Louisiana in collaboration with the licensed physician(s) or dentist(s).

Standard processing time for a PA application is 10-15 business days from the date of receipt at LSBN. Applications are processed in the order received. If any information on the application is incorrect, incomplete or illegible, processing of the application may be delayed. *The **APRN** will be notified in writing as soon as the PA application has been approved **or** if additional information is required*. Applications which have not been approved by LSBN within 60 days of receipt at the Board office will be closed without approval.

The application forms contained in this packet have been formatted in such a way that allow the APRN to 'type' the required data in the appropriate fields (shown on-screen as 'grey' boxes) on the first form (PAC 2), and any repetitive fields for the same data will automatically be copied into subsequent forms. For this reason, Board staff encourages the APRN to type/enter data on-screen, and then print completed forms. NOTE: If a data field ('grey' box) on a form is **non-**repetitive, the information will need to be entered.

All Collaborative Practice Agreements (CPA) submitted to LSBN must include recently dated '*original*' signatures of every party. All signatures should be in BLUE ink. White-out corrections are prohibited on the CPA and PA forms.

A CPA template form is available at the LSBN website. LSBN staff encourages the use of this template. If the APRN or his/her practice group wishes to draft their own CPA, it must comply fully with the guidelines for CPAs as provided for in L.R.S. 37:913 (3) (b), (8-9) and LAC 46:XLVII.4513. If the APRN's practice site requires an 'original' CPA for their records, then two (2) original CPAs would need to be prepared, printed and signed by all parties - one (1) to submit to LSBN with applicable PA form(s) and one (1) for the practice site.

A 'checklist' is provided at the end of these instructions **for the APRN** as a guide to ensure he/she includes **all** documentation required by LSBN. Please follow this checklist carefully and **mail** all items listed on the checklist to LSBN ***in one (1) envelope***. The APRN should make a copy of the full packet ***prior*** to submission. Instructions and checklist are for the APRN's use and should not be returned to LSBN with the PA application.

If the APRN wishes to prescribe controlled substances (CS) with the new physicians/practice site, the CPA must identify the requested DEA Schedules (i.e. III-V, II non-narcotic for ADD/ADHD, full II narcotics). Additional documentation will be required **if** the APRN had not been previously approved by LSBN for the DEA Schedule(s) indicated on the CPA. Refer to the separate PA application packet 'How to Apply for Initial Request of Controlled Substances, or a Change in DEA Schedule Level for Controlled Substances' at the LSBN website for further information.

ELIGIBILITY REQUIREMENTS
To Reinstate Prescriptive Authority Privileges in Louisiana

1. Each collaborating physician (or dentist) must hold an active and unencumbered Louisiana license.
   - License verification for physicians is available through the Louisiana State Board of Medical Examiners (LSBME): www.lsbme.la.gov.
   - License verification for dentists is available through the Louisiana State Board of Dentistry (LSBD): www.lsbd.org.
2. APRN must hold a current, unencumbered Louisiana RN and APRN license issued by LSBN. If the APRN licensure lapses, expires or inactive status, the APRN **must** apply to LSBN for approval to 'reinstate' PA privileges.
3. The APRN's advanced practice (AP) license, issued by LSBN, must be in the specific advanced practice role(s) and population focus/foci (e.g. adult, family, pediatric, psych/mental health, etc.) as indicated on the PA applications forms and CPA submitted for this practice site.
4. APRN must have previously been awarded PA privileges with collaborating physician(s) that had been approved in writing by LSBN, and wishes to return to clinical practice.
5. ***If*** the APRN had **ceased practice** with his/her previously LSBN approved collaborating physicians for **more than 12 months**, **but less than 4 years**, the nurse shall submit evidence of 6 contact hours of continuing education in advanced pharmacotherapeutics applicable to the APRN's role and population focus for each 12 month period of non-prescribing practice.
6. ***If*** the APRN had **ceased practice** with his/her previously LSBN approved collaborating physicians for **4 years or more**, the nurse shall provide evidence for 500 hours of clinical practice in the APRN's role and population focus within the last 2 years. APRN practice in another State may be accepted to meet this requirement.

APRN RESPONSIBILITIES

- *The APRN is responsible* for obtaining written approval from LSBN for **all** collaborating physician(s) and/or dentists(s) **prior** to clinical practice.
- *The APRN is responsible* for advising LSBN in writing **within 30 days** regarding the deletion of a collaborating physician, dentist or practice site that had been previously approved by LSBN.
- *If the CPA and DOCP 1 form submitted for this request provides only **one (1)** collaborating physician for the new practice site - the APRN shall be responsible* in ensuring that the CPA clearly states he/she "***will not engage in medical diagnosis and management, including writing orders and/or prescriptions, in the absence of the collaborating physician***."
- *The APRN is responsible* for ensuring that a copy of his/her signed CPA and PA approval letters issued by LSBN are maintained at the clinical site where PA privileges are exercised and be able to produce this documentation for review during a site visit.
- *The APRN is responsible* for ensuring that the CPA and PA forms submitted to LSBN for review are complete and follow all instructions provided herein.
- *The APRN is responsible* for being familiar, knowledgeable and compliant with **all** current state and federal laws, rules and regulations affecting APRN practice including, but not limited to, the following:
  - LSBN Nurse Practice Act (R.S. 37:911 et seq.)
  - LSBN Rules and Regulations (APRN Rules - LAC Title 46, Part XLVII, Subpart 2, Chapter 45);
  - Louisiana State Board of Pharmacy (LABP) rules regarding prescribing practices (e.g. LAC 46:LIII.2511), www.pharmacy.la.gov
  - Federal law and regulations issued by the U.S. Department of Justice – Drug Enforcement Administration (DEA) www.deadiversion.usdoj.gov if APRN has been approved for controlled substances PA privileges by LSBN.
- *The APRN is responsible* for notifying LSBN of a change in address and/or contact information for his/her primary place of residence **within 30 days**. Nurses may verify and update their address/contact information electronically at the LSBN website www.lsbn.state.la.us through '**My Services**'.

CHECKLIST
To Reinstate Prescriptive Authority Privileges in Louisiana

The following PA forms, original CPA and fee must be **mailed** to LSBN together in **one (1) envelope:**

☐ Money order or bank cashier's check for **$100.00**, payable to: **Louisiana State Board of Nursing** (or **LSBN**). If the APRN's employer/practice site wishes to pay the PA application fee on the APRN's behalf, a 'company check' for the required $100.00 will be accepted, but must accompany the PA application forms and CPA outlined below. Personal checks, cash or credit card are not accepted. Fees are non-refundable.

☐ Completed **form PAC 2** – '**Request for Approval – Add Physician(s) for a New Practice Site'**. The PAC 2 form must be both signed and notarized.

☐ Completed **form DOCP 1** – '**Disclosure of Collaborating Physicians**'. All physician(s) for the practice site which the APRN is requesting collaborative practice and PA approval must be noted on this form.

- Louisiana medical license number and practice specialty area must be provided for each physician.
- The names of the physicians listed on form DOCP 1 must match the physicians signing the CPA.
- Please check the LSBME website www.lsbme.la.gov to ensure each collaborating physician has a current and unencumbered medical license. Collaborating dentists can be verified through the LSBD website: www.lsbd.org

☐ Completed **form NPS 1** – '**Notification of Practice Site(s)**'. List all site(s) for the employer/group where the APRN will practice, with the **primary** clinical site listed first (Site # 1).

☐ **Original CPA** – '**Collaborative Practice Agreement**' recently signed by the APRN and all physicians noted on form DOCP 1 for the practice site. Please note the following when preparing the CPA:

- ***If*** the CPA and DOCP 1 form submitted for the PA request provides only **one (1)** collaborating physician for the practice site - the CPA must clearly state that the APRN "***will not engage in medical diagnosis and management, including writing orders and/or prescriptions, in the absence of the collaborating physician***."

- ***If*** the APRN wishes to prescribe controlled substances (CS) for the practice site, the CPA must identify the requested DEA Schedules (i.e. III-V, II non-narcotic for ADD/ADHD, full II narcotics). Additional documentation will be required **if** the APRN had not been previously approved by LSBN for the DEA Schedule(s) indicated on the CPA. Refer to the separate PA application packet 'How to Apply for Initial Request of Controlled Substances, or a Change in DEA Schedule Level for Controlled Substances' at the LSBN website for further information. **Mail all PA/CS forms, original CPA, CS letter of explanation and fee to LSBN in one (1) envelope**.

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Additional documentation will be required when submitting an application to reinstate PA privileges **if** the APRN has ceased practicing with his/her collaborating physician(s) and/or dentist(s) previously approved by LSBN for the periods indicated below:

☐ **Non-prescribing practice for 12 months or more**: APRN must include evidence of 6 contact hours of continuing education in advanced pharmacotherapeutics applicable to the APRN's role and population focus for **each** 12 month period of non-prescribing.

☐ **Non-prescribing practice for 4 years or more**: Please contact the LSBN APRN Department at advancedpractice@lsbn.la.gov for further information ***prior*** to submitting an application for PA reinstatement.

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REQUEST FOR APPROVAL
ADD PHYSICIAN(S) FOR A NEW PRACTICE SITE
(FORM # PAC 2)

The PAC 2 form is to be utilized *only* when requesting prescriptive authority (PA) for collaborative practice with physician(s) for a **new practice site that has not been previously approved by LSBN** (i.e. new employment). Please refer to instructions for a full list of all PA forms, original collaborative practice agreement (CPA) and fee that must be mailed to LSBN ***along with*** the completed and notarized PAC 2 form for processing the request. The APRN will receive written verification sent to his/her home address of record to notify the nurse if the request has been approved, denied, or requires additional information.

APRN Name: _____
First Name Middle Name Maiden Name Married Name (If applicable)

Residence Address: _____
Street City State Zip

Email Address: _____ Home/Cell Phone: _____

☐ *Please check this box if any contact information provided above is **new**. Board staff will update your licensure file.*

RN License #_____ APRN License# _____

Social Security Number: _____ Date of Birth: _____

Current role/category of practice as an APRN: ☐ CNS ☐ CNP ☐ CNM ☐ CRNA

Clinical population focus (Family, Pediatric, Adult, Psychiatric, etc.): _____

Position Title: _____

☐ **CHECK HERE IF YOU AUTHORIZE LSBN TO SEND YOUR APPROVAL LETTER TO YOUR EMAIL ADDRESS**

Provide below **the reason**(s) for requesting this change of PA privileges for collaborative practice in detail. Indicate if requesting approval for an additional site for a PRN position. **Provide names of any physicians and sites to be deleted**:

_____

_____

_____

_____

****

AFFIDAVIT

_____ (print name of APRN applicant) being duly sworn according to law, deposes and says that he/she is the person referred to in this application requesting approval for prescriptive authority, that the statements herein contained are true in every respect; that prescriptive authority will only be utilized with collaborating physicians approved in writing by LSBN for the APRN, and that he/she has read and understands this affidavit and will abide by all LSBN rules and regulations, including those relating to APRN and PA practice as specified in accord with LAC Title 46, Part XLVII, Subpart 2, Chapter 45.

Signature of APRN Applicant _____

Subscribed and sworn to before me on _____, 20_____.

_____ _____
Notary Public **Date Commission Expires**

Bar Roll/Notary #:_____

Revised: 3/02, 7/02, 1/04, 5/04, 8/05, 8/06, 2/08, 3/12, 4/14

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DISCLOSURE OF COLLABORATING PHYSICIANS
(FORM # DOCP 1)

Complete DOCP 1 form(s), providing **all** information requested, and submit to LSBN *along with* appropriate prescriptive authority (PA) application form(s) and original collaborative practice agreement (CPA). Please refer to the PA instructions to determine if a fee must accompany the submission to LSBN. Additional DOCP 1 forms may be utilized if needed to list all physician(a) and/or dentist(s) with this practice site. **The names of the physician(a) and/or dentist(s) listed on the DOCP 1 form(s) must match those signing the CPA for the practice site**. All collaborating physician(s) and/or dentist(s) must hold an active and unencumbered Louisiana license.

APRN Name: _____
First Name Middle Name Maiden Name Married Name (If applicable)

RN License # _____ APRN License# _____

COLLABORATING PHYSICIAN(s)

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

BACK UP PHYSICIAN(s)

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

Physician Name: _____
LA Medical License #: _____
Practice Specialty: _____

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NOTIFICATION OF PRACTICE SITE(S) FOR PRESCRIPTIVE AUTHORITY (FORM # NPS 1)

Complete NPS 1 form, listing **each** practice site where the APRN will be exercising prescriptive authority (PA) privileges for the collaborating physician(s) and/or dentist(s) named on the attached original collaborative practice agreement (CPA). List the **primary** clinical practice site first (# 1). Complete all information for each practice site. Make additional copies of this form as needed. Please refer to instructions for a full list of all PA forms, CPA and fee that must be mailed to LSBN ***along with*** this completed form.

APRN Name: _____
First Name Middle Name Maiden Name Married Name (If applicable)

RN License # _____ APRN License# _____

Clinical practice site(s) where I will be exercising prescriptive authority with the physicians named on the attached CPA is:

1. PRIMARY Site Name: _____

Street/physical address of the clinical practice site named above: _____

_____
City State Zip Code Parish

Office Phone Number: _____ Fax Number: _____

2. Site Name: _____

Street/physical address of the clinical practice site named above: _____

_____
City State Zip Code Parish

Office Phone Number: _____ Fax Number: _____

3. Site Name: _____

Street/physical address of the clinical practice site named above: _____

_____
City State Zip Code Parish

Office Phone Number: _____ Fax Number: _____

4. Site Name: _____

Street/physical address of the clinical practice site named above: _____

_____
City State Zip Code Parish

Office Phone Number: _____ Fax Number: _____

5. Site Name: _____

Street/physical address of the clinical practice site named above: _____

_____
City State Zip Code Parish

Office Phone Number: _____ Fax Number: _____

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