

# Example Pharmacy Medication Administration Protocol: Authority to Administer Injectable Drug Products (IM/SC)

**Purpose:** To set forth a procedure for the administration of intramuscular (IM) and subcutaneous (SC) injectable drug products by pharmacists credentialed by the <insert state> Board of Pharmacy to administer medications on behalf of practitioners in collaboration.

**Policy:**

This protocol is intended to ensure the safety, efficacy, and provision of administering injectable drug products by the designated pharmacist to meet the needs of patients who are 18 years of age or older and who may require such medication administration. Furthermore, a student pharmacist is authorized to administer injectable drug products if properly certified and if under the supervision of the designated pharmacist.

**Definitions:**

- “Side Effect” means an expected, well-known reaction resulting in little or no change in patient management.
- “Adverse Drug Reaction” means any unexpected, unintended, undesired, or excessive response to a drug that:
  - Requires discontinuing the drug;
  - Requires changing the drug therapy;
  - Requires modifying the dose (except for minor dose adjustments);
  - Necessitates admission to a hospital;
  - Prolongs stay in a health care facility;
  - Necessitates supportive treatment;
  - Significantly complicates diagnosis;
  - Negatively affects prognosis; or
  - Results in temporary or permanent harm, disability, or death.

**Process:**

(Name of Pharmacist) \_\_\_\_\_,  
Pharmacist License # \_\_\_\_\_,  
acting as an agent for the undersigned practitioner, may independently administer any intramuscular or subcutaneous medication injections, within a licensed pharmacy given that the following requirements are met.

**Requirements for Pharmacy Administration:**

The patient must be a current patient of <Pharmacy>, and the prescription order to be administered must be fulfilled by <Pharmacy>. In addition, the administration must take place within the <Pharmacy> location. The order must be written, received electronically or if received orally be reduced to writing, and must contain at a minimum the:

- Identity of the practitioner or nurse practitioner issuing the order;
- Identity of the patient to receive the injection;
- Identity of the medication and dose to be administered;
- Date of original order and the date or schedule, if any, of each subsequent administration.

**Requirements for Formal Chaperone:**

In addition to the pharmacist providing the administration, one additional <Pharmacy> employee must be present in the room as a formal chaperone. This information also will be documented on the Medication Administration Record.



**Requirements for Screening:** The pharmacist administering drug products shall meet the following requirements for screening:

- All patients should be screened for associated contraindications and precautions prior to the administration of the designated drug product, even if the patient has previously received the drug product.
  - If high-risk patients are identified, the pharmacist shall document this in the computer system prior to administration of the drug product.

**Requirement for Providing Patient Education:**

The pharmacist administering the drug product shall meet the following requirement:

- The pharmacist is required to provide patient counseling on the possible side effects and adverse drug reactions that might occur with the administration of the drug product.

**Requirements for Documentation and Communication:**

The pharmacist administering the drug product shall meet the following recordkeeping requirements:

- When administration has occurred pursuant to a written protocol, the pharmacist shall notify the ordering practitioner or nurse practitioner within 14 days of the following information:
  - Identity of the patient;
  - Identity of the medication;
  - Dose, route, and site of administration;
  - Date/time of actual administration;
  - Lot number and National Drug Code;
  - Disposition of any adverse events or reactions experienced by the patient and actions taken by the practitioner in regard to these events; and
  - Name and signature of the pharmacist who administered the medication.

- For every patient receiving an injection administration, the Medication Administration Record must be completed in its entirety. The patient MUST sign the Medication Administration Record.
- Every record, including notification, must be kept by the administering pharmacist and by the pharmacy when in legal possession of the drugs administered for at least two years from the date of administration.
- Pharmacists should notify the prescriber of deviations from the care plan, missed appointments for medication administration, and any problems with the administered medication.

**Adverse Event Procedures and Reporting:**

- When administering any medication in injection form, the patient will be instructed to remain in the pharmacy for an additional 20 minutes to observe for signs or symptoms of an adverse drug reaction.
- If an adverse drug reaction is identified, it is the responsibility and professional obligation of the pharmacist to report any significant adverse drug reactions to the ordering practitioner no later than 24 hours after identification or notification of the occurrence.
  - In the event of a life-threatening adverse drug reaction occurring, the pharmacist is authorized to administer epinephrine (0.01 mg/kg body weight; maximum of 0.5 mg per dose) or diphenhydramine (1-2 mg/kg, up to 50 mg maximum single dose) by appropriate routes pending arrival of emergency medical services to children up to 33 lb, and EpiPen Jr (0.15 mg) to children 33 lb–66 lb. Patients over 66 lb can be administered EpiPen (0.3 mg).
  - The health care professional covered under this protocol will maintain current certification in cardiopulmonary resuscitation or basic cardiac life support.



I hereby acknowledge the stipulations set forth and provide permission for the pharmacist to administer medications to his/her patients as long as the pharmacist complies with the requirements previously denoted.

This authorization shall be valid until 24 months from the date indicated on the bottom of this form, unless revoked in writing sooner or unless extended in writing.

Practitioner's Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Medical License Number: \_\_\_\_\_

Telephone Number for Consultations: \_\_\_\_\_

Pharmacist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_