

Application
LIMITED PURPOSE SCHEDULE II PERMIT (LPSP)
FOR CERTIFIED REGISTERED NURSE PRACTITIONERS;
CERTIFIED NURSE MIDWIVES AND PHYSICIAN ASSISTANTS

WARNING: Board Rules state that an LPSP may be suspended or revoked by the Board upon a finding that an individual has furnished false or fraudulent material information in this application.

Return Completed Application To:
ALABAMA STATE BOARD OF MEDICALEXAMINERS
Mailing Address: Physical Address:
P.O. Box 946 848 Washington Ave
Montgomery, AL 36101 Montgomery, AL 36104

Part A:

Name in full: _____
 First Middle Last

Permanent address: _____
 Street City State Zip

Phone number: _____ Cell Number (Optional): _____

Email address: _____

Part B:

CHOOSE ONE (CRNP/CNM or P.A.):

_____ CRNP/CNM – I swear (affirm) I have a current, unrestricted:

A. RN License # _____ Collaborative Practice Agreement CP # _____

B. QACSC # _____ DEA # _____ Expires _____

OR

_____ P. A. – I swear (affirm) I have a current, unrestricted:

A. PA License # _____ Registration Agreement RA # _____

B. QACSC # _____ DEA # _____ Expires _____

Part C:

This LPSP will be used with Collaborating/Supervising Physician: _____

Collaborating/Supervising Physician's Medical Specialty: _____

Part D:

We swear(affirm) that the information set forth in this application for the Limited Purpose Schedule II Permit is true and correct to the best of our knowledge, information and belief.

Physician Signature

Date

Mid-Level Practitioner Signature and Title

Date

Limited Purpose Schedule II Permit Application Formulary

As set forth in AL Code § 20-2-260, the Alabama Board of Medical Examiners may grant a Limited Purpose Schedule II Permit to a Certified Registered Nurse Practitioner, Certified Nurse Midwife or Physician Assistant who has a current, unrestricted license to practice in the State of Alabama, a current Collaborative Agreement or Registration Agreement; and a current, active, unrestricted Qualified Alabama Controlled Substance Certificate (QACSC) for Schedules III, IV and V, and current DEA license.

CRNP/CNM/PA printed name: _____ Specialty: _____

Signature of CRNP/CNM/PA: _____ Date: _____

Physician printed name: _____ Specialty: _____

Signature of physician: _____ Date: _____

I authorize the above named ___CRNP/CNM___PA (choose one) to prescribe and/or administer Controlled II Medications only as indicated below:

Choose	Generic	Frequently Used Brands	Brief Indication for your practice (attach additional pages if more space is needed) PRINT OR TYPE
	ADHD Medications: Methamphetamine; Methylphenidate; Dexmethylphenidate HCL; Dextroamphetamine; Lisdexamphetamine Dimesylate; Amphetamine Sulfate	Adderall; Adderall XR; Concerta; Daytrana; Dexedrine; Evekeo; Focalin; Focalin XR; Metadate CD; Metadate ER; Methylin; Procentra; Quillivant; Quillivant XR; Ritalin; Ritalin LA/SR; Vyvanase; Zenedi	
	Hydrocodone Combinations	Anexsia; Hycet; Ibudone; Maxidone; Norco; Norco Elixir; Reprexain; Vicoden; Vicoprofen; Zydone	
	Hydrocodone (Cough preparations)	Hycodan; Hydromet; Tussicaps; Tussionex PK; Zutripro; Tussigon	
	Morphine Sulfate-Immediate Release	MSIR	
	Oxycodone-Immediate Release	Endocet; Oxy IR; Oxyfast; Roxicodone; Percocet; Percodan; Roxicet; Tylox	
	Tapentadol	Nucynta	

Print CRNP/CNM/PA Name

Medications listed on this page are considered to be long acting and are subject to the following standard: ***“Initial dose and any subsequent escalation of the dose must be written by the physician with CRNP/CNM/PA writing maintenance doses only”***. These medications should only be requested for Hospice/Palliative Care; Nursing Home; or Oncology.

Choose	Generic	Frequently Used Brands	Brief Indication for your practice (attach additional pages if more space is needed) PRINT OR TYPE
	Fentanyl-Long Acting	Duragesic	
	Hydrocodone-ER/LA	Hydro ER; Hysingla; Zohydro	
	Hydromorphone	Dilaudid; Dilaudid HP; Exalgo	
	Morphine Sulfate-Long Acting	Avinza; Kadian; MS Contin; Oxymorph; Roxanol	
	Oxycodone-Long Acting	OxyContin; Xartemis XR	
	Oxymorphone-Long Acting	Opana; Opana ER	
	Tapentadol-Extended Release	Nucynta; Nucynta ER	

If additional medications are needed in the future, you may submit an additional formulary request.

To: Alabama Board of Medical Examiners

LPSP Covering Physician Agreement

As a covering (back-up) physician providing medical direction and oversight for

_____, _____ PA _____ CRNP/CNM (choose one), by signing this document, I hereby affirm that:

1. I am familiar with the Board rules regarding the mid-level practitioners and their ability to prescribe Schedule II controlled substances with a Qualified Alabama Control Substance Certificate (QACSC).
2. I am approved as a covering physician for the mid-level's QACSC.
3. I am familiar with the Board Rules governing the Limited Purpose Schedule II Permit (LPSP).
4. I have a current and unrestricted Alabama Controlled Substance Certificate, #_____.
5. I will be accountable for adequately providing medical direction and oversight for the prescribing of the Schedule II controlled substances allowed under this LPSP.
6. I will assume all responsibility for the controlled substance prescribing of the mid-level practitioner during the temporary absence of the primary Collaborating/Supervising Physician.

Telephone number _____ Fax Number _____

Medical Specialty of the Covering Physician _____

Print Physician Name

Physician License #

Physician Signature

Date