Prescribing Protocols

To be completed by Provider, in the event of their election to not have an active DEA.

I, ____SPECIALTY________________________________, have

elected not to renew my DEA for the following reason:

____

____

____

My protocol for when prescriptions are needed is as follows:

____

____

____

SIGNATURE OF PRACTITIONER

____

Signature Print Name

____

Date

SIGNATURE OF PRESCRIBING PRACTITIONER

____

Signature Print Name

____

Date

PLAN MUST BE NOTIFIED IN WRITING OF ANY CHANGE IN PROTOCOLS AND/OR DEA STATUS. PLEASE RETURN THE COMPLETED FORM TO YOUR PROVIDER RELATIONS REPRESENTATIVE.

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