OPTOMETRIST, THERAPEUTIC OPTOMETRIST & GLAUCOMA SPECIALIST
TEXAS PRESCRIBING AUTHORITY SUPPLEMENTAL QUESTIONNAIRE

Please note the type of Optometrist License you currently hold (Pursuant to the Texas Administrative Code, Title 22, Part 14, Chapter 280, Rule §280.5 and Rule 280.10, Texas Optometry Act). Optometrist who prescribes Schedule II – V or Schedule III - V controlled substances (dependent upon state licensure requirement), including oral analgesics and ocular pharmaceutical agents, shall have been granted prescribing certification or licensure by the state licensing board and must be registered with the DEA and DPS in accordance with the Texas Optometry Act.

- **Optometrist**: (License number will consist of a number without letters)
  
  An Optometrist **may not** prescribe prescription drugs for their patients. *(Neither a DEA or DPS certificate is required.)*

- **Therapeutic Optometrist**: (License number will consist of a number followed by the letter T (ex: 1234T)).
  
  A Therapeutic Optometrist may administer or prescribe drugs to treat the eye and adnexa (tissue surrounding the eye), but may not prescribe drugs for the treatment of glaucoma. A Therapeutic Optometrist may issue prescriptions for drugs consisting of over-the-counter oral medications, topical prescription medications for certain classifications of drugs and topical antivirals.

- **Optometric Glaucoma Specialist**: (License number will consist of a number followed by the letters TG (ex: 5678TG)).
  
  Optometric glaucoma specialists are therapeutic optometrists who may treat glaucoma. They have all of the privileges of a therapeutic optometrist but have an expanded formulary of drugs, including certain oral medications, from which they may prescribe.

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1. **Do you plan to prescribe controlled substances?** Therapeutic Optometrist (Schedule II-V) or Optometric Glaucoma Specialist (Schedule II-V)
   - **YES**
   - **NO**
   
   If **NO**, STOP HERE, attest to this document by signing/dating and returning.

2. **If YES**, do you possess a State Controlled Substance Certificate (CDR/CSR/BNDD/DPS)? Submit a copy of your certificate. **YES**
   - **NO**
   
   If **NO**, please explain why: ____________________________________________

3. **If YES**, do you possess a Federal Controlled Substance Certificate (DEA)? Submit a copy of your certificate. **YES**
   - **NO**
   
   If **NO**, do you practice in one of the following capacities? If so, you are automatically exempt from this requirement and no other explanation will be required.
   - **YES**
   - **NO**
     
     - Indian Health Service
     - Public Health Service
     - Federal Bureau of Prisons
     - Military Practitioners
     - Organizational DEA (practitioners who are employed by an educational institution or research institution)
     - Other: If you are exempt by regulation for any other reason, please provide a statement of the reason for the exception: ____________________________________________

If **NO** to questions 2 or 3, please provide the name of the practitioner(s) who will prescribe for patients who need prescriptions for medications requiring a DEA or State Controlled Substance certificate:

- **Practitioner Name:** ____________________________
- **Medical License No:** ___________  
- **State:** ___

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**Pending DEA or State Controlled Substance Certificates:** If the applicant/provider has a pending DEA application, the provider must have an agreement with a participating network provider with a valid DEA and State Controlled Substance Certificate (in each state where the applicant/provider intends to practice) to write prescriptions for the applicant/provider until the DEA application has been completed. Please submit a copy of the agreement or letter stating the name of the provider who will be writing prescriptions for the applicant/provider. If your DEA or DPS/CD/CSR certificates are pending, please list the name and Medical License Number of a practitioner who will prescribe for you:

- **Practitioner Name:** ____________________________
- **Medical License No:** ___________  
- **State:** ___

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**ATTESTATION:** I certify the information provided by me on this document is true, correct and compete to the best of my knowledge and belief. I understand and agree that any misstatement or omission of information concerning administering, dispensing or the prescribing of controlled substances may constitute grounds for withdrawal of the application for consideration.

- **Signature:** ____________________________  
- **Date:** ____________________________

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**Printed Name:** ____________________________

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**New Form:** 8/2012  **Revised:** 1/2013