State of New Hampshire
Board of Pharmacy

7 Eagle Square, Suite 300
Concord, NH 03301
(603) 271-2350 Fax: (603) 271-2856
www.oplc.nh.gov/pharmacy

NON-RESIDENT / MAIL-ORDER PHARMACY APPLICATION FOR PERMIT

Registration Fee $2,000.

☐ Check here if this application is being submitted as part of a ***change of ownership*** for a current NH registered mail-order pharmacy. If so, enter current NH Registration # NR_____

Pharmacy Name		
Street Address		
City	State	Zip Code
Direct Telephone Line To Pharmacist (For Board Inquiries) ( )	Pharmacy Fax Number ( )	Toll-Free Phone Number for Use by NH Residents ( )
Pharmacy E-Mail Address *(Must be entered in order to receive your license):*	Pharmacy Web Page Address	

Pharmacy Type (Check All That Apply):

☐ Community Pharmacy ☐ Home Infusion Pharmacy ☐ Long Term Care Pharmacy ☐ Research/Investigational
☐ Charitable Dispensing ☐ Nuclear Pharmacy ☐ Call Center ☐ Other *(Describe Below):*
☐ Central Prescription Processing **(Must Have Copy of Quality Assurance Program Available Upon Request)*

Name Of Pharmacist-In-Charge	Pharmacist License Number	State Of Issue
Pharmacy Hours Monday -Friday (Open – Close):	Saturday (Open – Close):	Sunday (Open – Close):
Hours Toll-Free Telephone Service Is Available Monday -Friday (Open – Close):	Saturday (Open – Close):	Sunday (Open – Close):

Type of Ownership

☐ Individual Owner/Trustee/Receivership ☐ Partnership ☐ Corporation / LLC ☐ *State Of Incorporation*:

Name Of Parent Company / Corporation / Owner	Telephone Number
Corporate / Owner's Mailing Address	
* If a Corporation, attach a copy of the *Certificate of Incorporation (NOT Articles of Incorporation)* from the State Where Company is Incorporated.	Pharmacy's Federal Tax ID# or FEIN#: _____

Types of Prescription Items Being Shipped to New Hampshire Residents:

☐ Non-Controlled Drugs ☐ Controlled Drugs ☐ Prescription Devices ☐ Prescription Diabetic Supplies
☐ None (Non-Dispensing) ☐ Non-Sterile Compounded Drugs (Patient-Specific Only) ☐ Other *(Describe):*

☐ Sterile Compounded Drugs (Patient-Specific Only) ** If shipping Sterile Compounded Products to NH Residents, you must attach items 1-5; additionally, by signing this application you acknowledge that the pharmacy has item #6 on hand and available upon request:*

1. Any and all GAP analysis reports related to the pharmacy done within the last twelve (12) months;
2. Any and all certification documents on compounding equipment done within the last six (6) months;
3. An inventory listing of any / all products shipped into the State of New Hampshire within the last six (6) months, including product, quantity, location of shipment, and date of shipment;
4. Any Department of Health and Human Services, Food and Drug Administration Inspection Reports (Form FDA 483) issued within the last twelve (12) months and any responses submitted to these agencies by the pharmacy;
5. Any state inspection reports issued within the last eighteen (18) months and any responses submitted to these agencies regarding the inspection reports by the pharmacy; and
6. The pharmacy's policies and procedures on sterile compounding. *(Do not attach – but must be available upon request).*

☐ **APPLICATION CONTINUED ON OTHER SIDE** ☐

Edit. Please insert page numbers. This change can be made at adoption.

Has the license/registration of this pharmacy ever been suspended, revoked, denied, voluntarily surrendered, placed on probation, or otherwise disciplined by any state or federal licensing/regulatory board/agency? ☐ Yes* ☐ No *If yes, attach explanation and copy of legal documents.

Have any of this applicant's owners, corporate officers, partners or pharmacists ever been found guilty of a felony in connection with the practice of pharmacy or distribution of drugs? ☐ Yes* ☐ No *If yes, attach explanation and copy of legal documents.

Is the pharmacy owned by an individual licensed to prescribe medicine, or does a prescriber (or a prescriber's immediate family member) have a majority/controlling interest in the pharmacy? ☐ Yes * ☐ No * If yes, what percentage is owned by a prescriber/prescriber's immediate family? _____%

Does the pharmacy have comprehensive liability insurance coverage? ☐ Yes ☐ No* *If no, please attach explanation.

ATTACHMENTS, ATTESTATION & SIGNATURE (All items must be checked; if #7 and #8 do not apply you must write 'N/A').
Be sure to include all required attachments with your application:

As Pharmacist-In-Charge, I confirm the following (must check each item), and I sign/date this application under penalty of perjury:

_____ 1. Copy is attached of the pharmacy's current license/registration issued by the Board of Pharmacy or other state regulatory agency where the pharmacy is located (home state);

_____ 2. Copy is attached of the pharmacy's most recent * pharmacy inspection report issued by the FDA, DEA, NABP, or State Board of Pharmacy where the pharmacy is located (home state) **Must have been within the past 18 months – if not, attach explanation. Your application may be placed on hold until a more recent inspection is made.*

_____ 3. Attached is a list containing the Name, Address, & Title of All Corporate Officers, Partners or Owner(s);

_____ 4. Attached is a prescription label, containing the name, address and phone number of the pharmacy, that would be used on finished prescription products mailed to New Hampshire residents;

_____ 5. A sample copy of a patient medication profile / nightly prescription print-out / drug utilization review report, that must include the following information:

A. Name and address of patient;
B. Name, address and DEA registration number of the prescriber;
C. Name, strength and quantity of drug dispersed;
D. Assigned prescription number;
E. Date of original filling; and
F. Date of refill(s).

_____ 6. One of the following *(A [Copy of current VIPPS Certificate from NABP or B [All 4 items listed under B]):*

A. Verified Internet Pharmacy Practice Site (VIPPS) accreditation from the National Association of Boards of Pharmacy; OR

B. The following materials (all 4 items must be submitted if the pharmacy is not VIPPS Certified)

I. At least 2 different photographs of the actual existing exterior, including the pharmacy signage, of the building in which the pharmacy will be or is currently located;

II. At least 2 different photographs of the prescription department as viewed by an approaching patron;

III. At least 4 different photographs of the prescription department as viewed from the interior, showing the prescription compounding area, refrigerator, water facilities, and pharmaceutical inventory storage area; and

IV. Scaled drawings of the pharmacy and drug storage area (which must include square footage).

_____ 7. Attached is a copy of the certificate of the alarm system in place or other proof the facility is alarmed;

_____ 8. Copy is attached of the pharmacy's current Federal DEA Registration Certificate if shipping controlled drugs. *If not handling/shipping controlled drug, write N/A*;

_____ 9. If shipping sterile compounded products, you must attach items 1 through 5 listed on page 1 of this application and assert that the pharmacy also has item 6 available. *If not shipping sterile compounded products, write N/A.*

This application will not be accepted without a signature and date of completion and without all required attachments.

If the pharmacy is exempt from registering with the PDMP, complete the following attestation:

"I attest, that the above-named pharmacy, for which I am the Pharmacist In Charge, is exempt from registering and reporting to the New Hampshire Prescription Drug Monitoring Program per NH RSA 318-B:33:

□ The Pharmacy does not have a Drug Enforcement Administration (DEA) Registration at all and does not do any business (dispensing, distributing, and/or shipping related to any Federally Scheduled Controlled Substances in either the pharmacy's home-state or any other U.S. State; or

□ The pharmacy only has a Drug Enforcement Administration (DEA) registration for schedule V Controlled Substances and does not do any business with Schedule II-IV Controlled Substances (dispensing, distributing, and/or shipping) in either the pharmacy's home-state or any other U.S. state – if selecting this box, you Must attach a copy of the pharmacy's current DEA registration.

By signing below I understand and affirm, that should the above-named pharmacy obtain a DEA registration for schedule II-IV and/or aspire to begin distributing/dispensing controlled substances in these schedules (either in its home-state or any other state), that I, and this pharmacy, will immediately notify the New Hampshire Board of Pharmacy and properly submit the required application as defined in Ph 904, and register with the NH Prescription Drug Monitoring Program as required by NH RSA 318-B:33".

_____
Printed Name of Pharmacist in Charge

_____ _____
Signature of Pharmacist in Charge Date of Signature

The signature of the pharmacist-in-charge and date below the following attestation:

I attest that I have read the NH Laws; RSA 318 and RSA 318-B and Administrative Rules for the profession that I have applied for on this renewal. I attest to reading Ph 904.01; which states in part, 'the Board must be notified within 30 days of any changes to any information from the original application'. I attest that I have answered all questions truthfully, accurately and I hereby attest that if any information on this application was submitted falsely or is misleading or a misrepresentation of the facts, I understand that such an act shall constitute cause for potential denial, revocation, or disciplinary actions of the registration that I am applying for. I understand that the pharmacy permit is issued in the name of the corporation or owner of the pharmacy and that a duly designated pharmacist in charge, as designated on this application, has accepted responsibility for the safe, effective operation of the pharmacy. My signature; ink or electronic; constitutes my acknowledgement of the responsibilities of both the pharmacist in charge and the corporation/owner/permit holder regarding the safe operation of the pharmacy.

_____
Printed Name of Pharmacist in Charge

_____ _____
Signature of Pharmacist in Charge Date of Signature