



State of New Hampshire
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
7 Eagle Square, Concord, NH 03301
Phone: 603-271-2152

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: _____

Direct Telephone # to Pharmacist (for business inquires): _____

Pharmacy Fax #: _____ Toll-Free Phone Number for Use by NH Residents:

Pharmacy E-Mail (must be entered in order to receive your license):

Pharmacy Web Address: _____

Pharmacy Type (check all that apply)

Community	Home Infusion	Long Term Care	Research/Investigational
Charitable Dispensing	Nuclear	Call Center	Other
Central Prescription Processing *(must have copy of quality assurance program available upon request)			

Name of Pharmacist-In-Charge: _____

License #: _____ State of Issue: _____

Pharmacy Hours: Monday-Friday (open to close): _____

Saturday (open to close): _____ Sunday (open to close): _____

Hours Toll-Free Telephone Service is Available: Monday -Friday (open to close): _____

Saturday (open to close): _____ Sunday (open to close): _____



State of New Hampshire Office of Professional Licensure & Certification

7 Eagle Square, Concord NH 03301
Phone: 603-271-2152

Type of Ownership

Individual Owner/Trustee/Receivership	Partnership	Corp / LLC	State of Inc.
---------------------------------------	-------------	------------	---------------

Name of Parent Company / Corporation / Owner: _____

Corporate / Owner's Mailing Address:

<ul style="list-style-type: none"> If a corporation, attach a copy of the <u>CERTIFICATE</u> of incorporation (NOT Articles of Incorporation) from the state where company is incorporated 	Pharmacy's Federal Tax ID #
---	-----------------------------

Types of Prescription Items being Shipped to New Hampshire Residents

Non-Controlled Drugs	Controlled Drugs	Prescription Devices	Prescription Diabetic Supp.
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 the 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 NH 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 FDA483) 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)



State of New Hampshire
Office of Professional Licensure & Certification

7 Eagle Square, Concord NH 03301
Phone: 603-271-2152

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.



State of New Hampshire
Office of Professional Licensure & Certification

7 Eagle Square, Concord NH 03301
Phone: 603-271-2152

- 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. 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;*

_____ 8. 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.*

I, _____, certify that the contents of this renewal are true
Pharmacist-In-Charge (Printed Name)

and correct to the best of my knowledge and belief and the above initialed items are attached as applicable.

Signature: _____ Date: _____