GENERAL GOVERNMENT CABINET

Kentucky Board of Pharmacy

(Amendment)

201 KAR 2:240. Special limited pharmacy permit – Charitable

RELATES TO: KRS 315.035

STATUTORY AUTHORITY: KRS 315.020, 315.030, 315.035, 315.191(1)(a)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.191(1)(a) authorizes the board to promulgate administrative regulations to prescribe the criteria for obtaining a pharmacy permit to dispense legend drugs and the procedures for the safe dispensing of legend drugs to citizens of the Commonwealth. This administrative regulation identifies the manner and procedure by which a charitable organization may obtain a pharmacy permit and dispense legend drugs in the Commonwealth.

Section 1. Definitions. (1) "Charitable organization" means an organization qualified as a charitable organization pursuant to Section 501(c)(3) of the Internal Revenue Code.

(2) "Legend drug sample" means an unopened package of a manufacturer's legend drug product that has been distributed to either a practitioner or the charitable pharmacy in accordance with the provisions of the Prescription Drug Marketing Act of 1987.

(3) "Qualified indigent patient" means a patient of the charitable pharmacy that has been screened and approved by the charitable organization as meeting the organization's mission of

providing pharmaceutical care to those who are without sufficient funds to obtain needed legend drugs.

(4) "Special limited pharmacy permit" means a permit issued to a pharmacy that provides specialized pharmacy services, such as dispensing legend drugs, and counseling patients.

Section 2.

(1) A charitable pharmacy:

(a) Shall comply with all pharmacy permit requirements except those specifically exempted by the board pursuant to paragraph (b) of this subsection; and

(b) May petition the board in writing to be exempted from those pharmacy permit requirements that do not pertain to the operation of that charitable pharmacy.

(2) The charitable pharmacy only shall dispense prescription legend drug samples or prescription legend drugs to qualified indigent patients of the pharmacy.

(3) The charitable pharmacy shall not charge any fee for the dispensing of prescription legend drug samples or prescription legend drugs to qualified indigent patients of the pharmacy.

(4) A charitable pharmacy may accept prescription legend drugs in their unbroken original packaging from pharmacies, wholesalers, or manufacturers, provided appropriate records of receipt and dispensing are maintained.

(5) A charitable pharmacy shall not:

(a) Accept controlled substances from pharmacies, wholesalers, or manufacturers; or

(b) Dispense controlled substances.

(6) A pharmacy that requests a special limited pharmacy permit - charitable shall submit to the board for prior approval, a plan describing the method by which the charitable pharmacy and the pharmacy shall maintain a separate and distinct prescription drug stock. The failure of either

pharmacy to follow the plan shall result in revocation of the special limited pharmacy permit - charitable and the pharmacy permit.

Section 3. License Fees; Renewals. An applicant shall submit:

(1) An initial or renewal application for a special limited pharmacy permit - charitable pharmacy on either the Application for Special Limited Pharmacy Permit – Charitable Pharmacy or the Application for Special Limited Pharmacy Permit – Charitable Pharmacy Renewal; and

(2) As appropriate, the:

(a) Initial application fee established by 201 KAR 2:050, Section 1(8); or

(b) Renewal fee established by 201 KAR 2:050, Section 1(9) and (10).

Section 4. Incorporation By Reference.

(1) The following material is incorporated by reference:

(a) "Application for Special Limited Pharmacy Permit – Charitable Pharmacy", June 2023 [~~May 2020~~]; [~~and~~]

(b) "Application for Special Limited Pharmacy Permit – Charitable Pharmacy Renewal", June 2023 [~~May 2020~~].

(c) "Application for Non-Resident Special Limited Pharmacy Permit – Charitable Pharmacy", June 2023; and

(d) "Application for Non-Resident Special Limited Pharmacy Permit—Charitable Pharmacy", June 2023.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Pharmacy, 125 Holmes Street, Suite 300, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. This material is also available on the board's Web site at https://pharmacy.ky.gov/Businesses/Pages/Pharmacy.aspx.

June 7, 2023

Christopher Harlow, Pharm.D.
Executive Director
Board of Pharmacy

Date

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall be held on August 30, 2023, at 10:00 a.m. Eastern Time via zoom teleconference. Individuals interested in being heard at this hearing shall notify this agency in writing by five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted through August 31, 2023. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

Contact person: Christopher Harlow, Executive Director, Kentucky Board of Pharmacy, 125 Holmes Street, Suite 300, State Office Building Annex, Frankfort, Kentucky 40601, phone (502) 564-7910, fax (502) 696-3806, email Christopher.harlow@ky.gov.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

201 KAR 2:240 Special Limited pharmacy – charitable pharmacy
Contact person: Christopher Harlow, Phone 502-564-7910
Email: christopher.harlow@ky.gov

(1) Provide a brief summary of:

(a)What this administrative regulation does: This administrative regulation identifies the manner and procedure by which a charitable organization can be permitted to obtain a pharmacy permit and dispense legend drugs in the Commonwealth.

(b) The necessity of this administrative regulation: KRS 315.020, 315.030, and 315.191(1)(a) requires the board to promulgate administrative regulations to prescribe the criteria for obtaining a pharmacy permit to dispense legend drugs and the procedures for the safe dispensing of legend drugs to citizens of the Commonwealth. This administrative regulation identifies the manner and procedure by which a charitable organization can be permitted to obtain a pharmacy permit and dispense legend drugs in the Commonwealth.

(c) How this administrative regulation conforms to the content of the authorizing statues: This administrative regulation identifies the manner and procedure by which a charitable organization can be permitted to obtain a pharmacy permit and dispense legend drugs in the Commonwealth

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation identifies the manner and procedure by which a charitable organization can be permitted to obtain a pharmacy permit and dispense legend drugs in the Commonwealth

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This amendment is only to the applications.

(b)The necessity of the amendment to this administrative regulation: The criteria needed to be updated.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 315.020 and 315.030 authorize the board to regulate the practice of pharmacy. KRS 315.191 authorizes the board to promulgate administrative regulations pertaining to pharmacists and pharmacies.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will further promote, preserve, and protect public health through effective regulation of pharmacists and pharmacies.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The board anticipates pharmacies and pharmacists will be affected minimally by this regulation amendment.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Pharmacies and pharmacists will have to familiarize themselves with amended language. The board will help to educate pharmacists and pharmacies in these changes.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are no expected costs for the permitted entities to comply with the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The ability to function as a permitted pharmacy.

(5) Provide an estimate of how much it will cost to implement this administrative Regulation:
(a) Initially: No costs will be incurred.
(b) On a continuing basis: No costs will be incurred.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Board revenues from pre-existing fees provide the funding to enforce the regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding will be required because of this new regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? (Explain why tiering was or was not used) Tiering is not applied because the regulation is applicable to all charitable pharmacies equally.

FISCAL NOTE

201 KAR 2:240 Special Limited pharmacy – charitable pharmacy
Contact person: Christopher Harlow
Phone 502-564-7910
email christopher.harlow@ky.gov

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Board of Pharmacy will be impacted by this administrative regulation.
2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 315.191(1)(a).
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate revenue for the board in the first year.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate revenue for the board in subsequent years.

(c) How much will it cost to administer this program for the first year? The costs to operate this program are built into the board's operating costs.

(d) How much will it cost to administer this program for subsequent years? The costs to operate this program are built into the board's operating costs.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation. N/A

Revenues (+/-): 0
Expenditures (+/-): 0
Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year? None

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years? None.

(c) How much will it cost the regulated entities for the first year? $150 annually.

(d) How much will it cost the regulated entities for subsequent years? $150 annually.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Cost Savings (+/-): 0

Expenditures (+/-): $150
Other Explanation: This is the cost of the permit to operate.

(5) Explain whether this administrative regulation will have a major economic impact, as defined below. "Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)] This regulation does not have major economic impact.

Summary of Material Incorporated by Reference

The “Application for Resident Special Limited Pharmacy Permit – Charitable Pharmacy”, June 2023 form is a 6-page form to be utilized by applicants for an initial permit.

The “Application for Resident Special Limited Pharmacy Permit – Charity Pharmacy Renewal”, June 2023 is a 6-page form is to be utilized by applicants for annual permit renewal.

The “Application for Non-Resident Special Limited Pharmacy Permit – Charitable Pharmacy”, June 2023 form is a 6-page form to be utilized by non-resident applicants for an initial permit.

The “Application for Non-Resident Special Limited Pharmacy Permit – Charity Pharmacy Renewal”, June 2023 form is a 6 page form to be utilized by non-resident applicants for annual permit renewal.

Summary of Changes to Material Incorporated by Reference

The “Application for Resident Special Limited Pharmacy Permit – Charitable Pharmacy” and“ Application for Resident Special Limited Pharmacy Permit – Charity Pharmacy Renewal” were amended to ask for the website address, how the entity is registered with the Kentucky Secretary of State, and to include changes to formatting, the exclusion of content that is no longer relevant and the inclusion of content that is relevant in assessing if a license should be issued or renewed. The “Application for Non-Resident Special Limited Pharmacy Permit – Charitable Pharmacy” and “Application for Non-Resident Special Limited Pharmacy Permit – Charity Pharmacy Renewal” are new forms.

KENTUCKY BOARD OF PHARMACY
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601
Phone (502) 564-7910
Fax (502) 696-3806
e-mail: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Resident Special Limited Pharmacy Permit - Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal.
Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

1. Name of Facility: _____

Physical Address of Facility: _____
(Street and Number)

City: _____ County: _____ State: _____Zip: _____

Phone Number: _____ Fax Number: _____

Email Address _____
Website Address_____

Mailing Address of Facility: _____
(Street and Number)

City: _____State: _____Zip: _____

Check and complete one of the following and attach proper fee:

☐ New Facility . . . . . $150.00~~125.00~~

Proposed date of Opening _____

(Filed with Board 30 days in advance of Opening) **or** Current Permit No. _____ Expiration Date _____
(In State where presently located)

☐ Change of Ownership . . . . . $0 ~~75.00~~

Date of Proposed Acquisition _____

Name of Previous Owner(s) _____

(Confirmation statement of previous owner must be attached)

☐ Change of Address/Location . . . . . $0 ~~75.00~~

Date of Proposed Relocation _____

Previous Address _____

☐ Name Change . . . . . $0 ~~$ 5.00~~

Previous Name _____

2. Ownership:

☐ Sole Proprietor ☐ Partnership ☐ LLC ~~Unincorporated Business~~ ☐ Corporation ~~Incorporated Business~~ ☐ Other

Name and title for each owner/officer/member, including professional designation *(e.g. Pres. John Jones, PharmD)*

_____

_____

3. Pharmacist in Charge:

Form 1 – June 2023

Name _____ KY License No. _____

Kentucky Pharmacy Regulation 201 KAR 2:205 requires Pharmacist in Charge to notify the Board within fourteen (14) calendar days of all pharmacist personnel changes.

4. Name and license/registration number of pharmacy employees.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

5. Name and title of each non-pharmacist with keys to the pharmacy:

_____

_____

6. Schedule of Hours:

Monday . . . . _____ A.M. to _____ P.M. Friday . . . _____ A.M. to _____ P.M.

Tuesday . . . _____ A.M. to _____ P.M. Saturday . . _____ A.M. to _____ P.M.

Wednesday _____ A.M. to _____ P.M. Sunday . . . _____ A.M. to _____ P.M.

Thursday . . . _____ A.M. to _____ P.M. **Please indicate if closed for lunch. _____**

**P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.

7. ~~Discipline Qualifying Questions~~

Has any owner , member or officer been subject to discipline by any other agency related to the ownership or employment in a pharmacy? ___yes ___no (If yes, please attach a statement).

~~Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted of any felony under federal, state, and/or local laws?~~

~~☐ Yes, attach explanation ☐ No~~

~~Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever has a wholesale distributor license/permit revoked or suspended by any federal, state, or local government?~~

~~☐ Yes, attach explanation ☐ No~~

~~Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted under federal, state and/or local laws relating to drug samples and wholesale or retail drug distribution of controlled substances?~~

~~☐ Yes, attach explanation ☐ No~~

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121

I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws, and that the facility is currently licensed and in good standing in all states of licensure DATE.

_____ _____

(Original Signature of Owner) (Original Signature of Pharmacist in Charge)

_____ _____

(**DATE**) (**DATE**)

I hereby certify that the above **Application for Resident Pharmacy Permit** was signed, subscribed and sworn to before me this _____day of _____, 20____

By:_____
Signature_____

My Commission Expires_____State of _____

I hereby certify that the above **Application for Resident Pharmacy Permit** was signed, subscribed and sworn to before me this_____day of _____, 20____

By:_____

Signature_____

My Commission Expires_____State of_____

KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
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Phone:(502) 564-7910
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Email: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email Address:
Phone Number:
Fax number:
Website Address:

II. Check and complete one of the following and attach proper fee:

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

☐ **Change of Ownership** → **$0**

Proposed date of Acquisition:
Name of Previous Owner(s):

(Confirmation statement of previous must be attached)

☐ **Change of Address/Location** → **$0**

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → $0**

Previous Name:

III. Ownership:

How is the pharmacy registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★Name and title for each owner/officer/member, including professional designation (e.g. Pres. John Jones, PharmD):

Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

(Use supplemental information page if necessary)

IV. Pharmacist in Charge:

Name:	KY License No.:

Kentucky Pharmacy Regulation 201 KAR 2:205 requires the Pharmacist in charge to notify the Board within fourteen (14) calendar days of all pharmacist personnel changes.

V. Name and license/registration number of pharmacy employees:

Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :

(Use supplemental information page if necessary)

VI. Name and title of each non-pharmacist with keys to the pharmacy:

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

VII. Schedule of Hours:

(The Pharmacist in charge must notify the Board within fourteen (14) days of any changes in scheduled hours.)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

★Please indicate if closed for lunch:

_____ until _____

VIII. Discipline:

Has any owner , member or officer been subject to discipline by any other agency related to the ownership or employment in a pharmacy?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

Supplemental Information Page:

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121

I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws, and that the facility is currently licensed and in good standing in all states of licensure DATE.

Signature of Pharmacist-in-Charge: **Date:**

I hereby certify that the above Application for Resident Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

I hereby certify that the above Application for Resident Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Kentucky Permit Number
CH

KENTUCKY BOARD OF PHARMACY
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601
Phone (502) 564-7910
Fax (502) 696-3806
e-mail: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Resident Special Limited Pharmacy Permit - Charitable Pharmacy Renewal

Enclose a check or money order for $150.00~~125.00~~, made payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. Please print legibly and complete this application; including the required original signature and return no later than June 30th. ~~All renewals received after June 30th will be assessed a delinquent fee of $150.00100.00 pursuant to 201 KAR 2:050, Section 1(1011~~).

1. Name of Facility _____

Physical Address of Facility _____
(Street and Number)

City _____ County _____ State _____Zip _____

Phone Number _____ Fax Number _____

Email Address _____

Website Address_____

2. **Ownership. How is the pharmacy registered with the Kentucky Secretary of State?:**

☐ Sole Proprietor ☐ Partnership ☐ LLC ~~Unincorporated Business~~ ☐ Corporation ~~Incorporated Business~~☐ Other

Name and title for each owner/officer/member, including any professional designation *(e.g. Pres. John Jones, PharmD)*

_____

_____

___

3. Schedule of Hours:

*P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.

Monday	_____ A.M. to _____ P.M.	□ 24 Hours
Tuesday	_____ A.M. to _____ P.M.	□ 24 Hours
Wednesday	_____ A.M. to _____ P.M.	□ 24 Hours
Thursday	_____ A.M. to _____ P.M.	□ 24 Hours
Friday	_____ A.M. to _____ P.M.	□ 24 Hours
Saturday	_____ A.M. to _____ P.M.	□ 24 Hours
Sunday	_____ A.M. to _____ P.M.	□ 24 Hours

Please indicate if closed for lunch. _____

~~**Pharmacist in Charge:**~~

~~Name _____ KY License No. _____~~

Kentucky Pharmacy Regulation 201 KAR 2:205 requires Pharmacist in Charge to notify the Board within fourteen (14) calendar days of all

4. EMPLOYEE INFORMATION

Pharmacist-In-Charge(PIC): Name_____ KY License Number_____

Note: 201 KAR 2:205 requires the pharmacist-in-charge to notify the Board within fourteen [14] calendar days of all pharmacist changes.

Employees: Please provide a complete list of all employees licensed/registered with the Board. Use a separate sheet of paper if necessary.

NAME	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name, title and address of each non-pharmacist with keys to the pharmacy:

_____ _____

5. Discipline. Have you had a Pharmacy license/permit disciplined by any agency which you have not previously reported to this Board?

_____Yes, attach an explanation _____NO

~~**For institutional pharmacies, are there decentralized pharmacy services (i.e. oncology satellite, OR satellite, etc.) where drugs are prepared, stored, and/or compounded in the facility?**~~

_____ ~~**_____Yes, how many? _____NO**~~

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121

I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws, and that the facility is currently licensed and in good standing in all states of licensure.

_____ _____

(Original Signature of Owner) (Original Signature of Pharmacist in Charge)

_____ _____

(Date) (Date)

I hereby certify that the above **Application for Resident Special Limited Pharmacy Permit** was signed, subscribed and sworn to before me this _____day of _____, 20____

By:_____Signature_____

My Commission Expires_____State of _____

I hereby certify that the above **Application for Resident Special Limited Pharmacy Permit** was signed, subscribed and sworn to before me this_____day of _____, 20____

_____Signature_____

My Commission Expires_____State of_____

June 2023 ~~5/2020~~

KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
Frankfort KY 40601
Phone:(502) 564-7910
Fax:(502) 696-3806
Email: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy Renewal

Enclose a check or money order for $150.00, made payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Please print legibly and complete this application; including the required original signature and return no later than June 30th.

I. Facility Information:

Name of Facility:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:
Fax Number:

Website Address:

II. Ownership:

How is the pharmacy registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★Name and title for each owner/officer/member, including any professional designation (e.g. Pres. John Jones, PharmD):

Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

(Use supplemental information page if necessary)

III. Schedule of Hours:

(P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

EMPLOYEE INFORMATION:

1. Pharmacist in Charge (P.I.C.):

Name:	License No.:

Note: 201 KAR 2:205 requires the pharmacist-in-charge to notify the Board within fourteen [14] calendar days of all pharmacist changes.

2. Please provide a complete list of all employees licensed/registered with the Board:

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

3. Name, title and address of each non-pharmacist with keys to the pharmacy:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

4. Discipline:

Has any owner , member or officer been subject to discipline by any other agency related to the ownership or employment in a pharmacy?

☐ **YES***	☐ **NO**

***If yes:** Please explain below

:

Supplemental Information Page:

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121

I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws, and that the facility is currently licensed and in good standing in all states of licensure.

Signature of Pharmacist-in-Charge: **Date:**

I hereby certify that the above Renewal Application for Resident Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

I hereby certify that the above Renewal Application for Resident Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
Frankfort KY 40601
Phone:(502) 564-7910
Fax:(502) 696-3806
Email: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Non-Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email Address:
Phone Number:
Fax Number:
Website Address:

II. Check and complete one of the following and attach proper fee:

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

☐ **Change of Ownership** → **$0**

Proposed date of Acquisition:
Name of Previous Owner(s):

(Confirmation statement of previous must be attached)

☐ **Change of Address/Location** → **$0**

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → $0**

Previous Name:

III. Ownership:

How is the pharmacy registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★Please provide the following for each owner/officer/member, including professional designation (e.g. Pres. John Jones, PharmD):

Name:	Title:

Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:

Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):			
Phone Number(Business):			
Date of Birth:			
Social Security Number:			

Name:	Title:

Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:
Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):			
Phone Number(Business):			

Date of Birth:
Social Security Number:

Name:	Title:
Address (Home):	
CITY: STATE: COUNTY: ZIP:	
Address (Business):	
CITY: STATE: COUNTY: ZIP:	
Phone Number(Home):	
Phone Number(Business):	
Date of Birth:	
Social Security Number:	

Name:	Title:
Address (Home):	

CITY:	STATE:	COUNTY:	ZIP:

Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:

Phone Number(Home):

Phone Number(Business):

Date of Birth:

Social Security Number:

Name:	Title:

Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:

Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:

Phone Number(Home):

Phone Number(Business):
Date of Birth:
Social Security Number:

(Use supplemental information page if necessary)

IV. Pharmacist in Charge:

Name:	KY License No.:

Kentucky Pharmacy Regulation 201 KAR 2:205 requires the Pharmacist in charge to notify the Board within fourteen (14) calendar days of all pharmacist personnel changes.

V. Name and license/registration number of pharmacy employees:

Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :

(Use supplemental information page if necessary)

VI. Name and title of each non-pharmacist with keys to the pharmacy:

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

VII. Schedule of Hours:

(The Pharmacist in charge must notify the Board within fourteen (14) days of any changes in scheduled hours.)

MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

★Please indicate if closed for lunch:

_____ until _____

VIII. Discipline:

Has any owner , member or officer been subject to discipline by any other agency related to the ownership or employment in a pharmacy?

☐ YES*	☐ NO

If yes: Please explain below

:

IX. Does the pharmacy ship any prescriptions to the citizens of the Commonwealth of Kentucky under any name or return address other than the information of the pharmacy seeking or renewing a permit provided with this application?

☐ YES*	☐ NO

If yes: Please provide a list of the additional pharmacy name(s) or return addresses that the pharmacy ships prescriptions to citizens of the Commonwealth of Kentucky and why.

(Use supplemental information page if necessary)

X. List the methods of deliver services (e.g. USPS, UPS, FedEx, etc) utilized to deliver prescriptions to citizens of the Commonwealth of Kentucky and the percentage of time each service is utilized in Kentucky.

Delivery Service Utilized:	Percentage of Time:

(Use supplemental information page if necessary)

XI. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

Supplemental Information Page:

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REQUIRED DOCUMENTATION MUST BE ENCLOSED:

- ☐ Completed application
- ☐ Copy of Resident Pharmacy Permit
- ☐ Copy of Last Inspection Report
- ☐ Copy of DEA Registration
- ☐ Completed Attached License Verification Form or Primary Source Verification Form
- ☐ Sample Pharmacy Labels for Controlled and Non-Controlled Substances shipped into Kentucky
- ☐ Copy of the End-of-Day Report for the Seven (7) Business Days preceding the application date
- ☐ Copy of notarized *Memorandum of Understanding and Agreement*

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I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws, and that the facility is currently licensed and in good standing in all states of licensure DATE.

Signature of Pharmacist-in-Charge: **Date:**

I hereby certify that the above Application for Non-Resident Special Limited Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

I hereby certify that the above Application for Non-Resident Special Limited Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
Frankfort KY 40601
Phone:(502) 564-7910
Fax:(502) 696-3806
Email: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Non-Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy Renewal

Enclose a check or money order for $150.00, made payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Please print legibly and complete this application; including the required original signature and return no later than June 30th.

I. Facility Information:

Name of Facility:			
Kentucky Permit No.:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			
Phone Number:			
Fax Number:			

Website Address:

II. Ownership:

How is the pharmacy registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★Name and title for each owner/officer/member, including any professional designation (e.g. Pres. John Jones, PharmD):

Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

(Use supplemental information page if necessary)

III. Schedule of Hours:

(P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

EMPLOYEE INFORMATION:

1. Pharmacist in Charge (P.I.C.):

Name:	License No.:

Note: 201 KAR 2:205 requires the pharmacist-in-charge to notify the Board within fourteen [14] calendar days of all pharmacist changes.

2. Please provide a complete list of all employees licensed/registered with the Board:

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

3. Name, title and address of each non-pharmacist with keys to the pharmacy:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

IV. Discipline:

Have you had a Pharmacy license/permit disciplined by any agency which you have not previously reported to this Board?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

V. Does the pharmacy ship any prescriptions to the citizens of the Commonwealth of Kentucky under any name or return address other than the information of the pharmacy seeking or renewing a permit provided with this application?

☐ YES*	☐ NO

If yes: Please provide a list of the additional pharmacy name(s) or return addresses that the pharmacy ships prescriptions to citizens of the Commonwealth of Kentucky and why.

(Use supplemental information page if necessary)

VI. List the methods of deliver services (e.g. USPS, UPS, FedEx, etc) utilized to deliver prescriptions to citizens of the Commonwealth of Kentucky and the percentage of time each service is utilized in Kentucky.

Delivery Service Utilized: **Percentage of Time:**

(Use supplemental information page if necessary)

VII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

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I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws, and that the facility is currently licensed and in good standing in all states of licensure.

Original Signature of Pharmacist-in-Charge: **Date:**

I hereby certify that the above Application for Non-Resident Special Limit Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

I hereby certify that the above Application for Non-Resident Special Limited Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 6/2023