MEMORANDUM

TO: Eden S. Davis, General Counsel, Board of Pharmacy

FROM: Emily Caudill, Regulations Compiler

RE: Proposed Amendment or New Regulation – 201 KAR 002:3205

DATE: March 9, 2021

A copy of the administrative regulation listed above is enclosed for your files. This regulation is tentatively scheduled for review by the Administrative Regulation Review Subcommittee at its June 2021 meeting. We will notify you of the date and time of this meeting once it has been scheduled.

Pursuant to KRS 13A.280, if comments are received during the public comment period, a Statement of Consideration or a one-month extension request for this regulation is due by noon on June 15, 2021. Please reference KRS 13A.270 and 13A.280 for other requirements relating to the public hearing and public comment period and Statements of Consideration.

If you have questions, please contact us at RegsCompiler@LRC.ky.gov or (502) 564-8100.

Enclosures
1  BOARDS AND COMMISSIONS

2  Board of Pharmacy

3  (Amendment)


5  RELATES TO: KRS 315.020, 315.0351, 315.191, 315.300, 315.335

6  STATUTORY AUTHORITY: KRS 315.020(1), 315.0351, 315.191(1)

7  NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.191(1) authorizes the board to

8  promulgate administrative regulations pursuant to KRS Chapter 13A necessary to regulate and

9  control all matters relating to pharmacists, pharmacist interns, pharmacy technicians, pharmacies,

10 wholesale distributors, and manufacturers. KRS 315.020(1) and 315.0351(7) require applicants

11 for pharmacy permits to place a pharmacist in charge as a prerequisite to compounding and

12 dispensing privileges granted by the Kentucky Board of Pharmacy. This administrative

13 regulation establishes the requirements relating to a pharmacist-in-charge.

14 Section 1. Definition. "Pharmacist-in-charge" means a pharmacist licensed in the

15 Commonwealth of Kentucky, or in the appropriate jurisdiction of an out-of-state pharmacy

16 holding a Kentucky Board of Pharmacy permit, who accepts responsibility for the operation of a

17 pharmacy in conformance with all laws and administrative regulations pertinent to the practice of

18 pharmacy and the distribution of prescription drugs and who is personally in full and actual

19 charge of the pharmacy.
Section 2. Duties and Responsibilities. (1) The pharmacist-in-charge shall be so designated in the application for a permit to operate a pharmacy and in each application for renewal of that permit thereafter.

(2) A pharmacist shall not serve as a pharmacist in charge:
   (a) For more than one (1) pharmacy at a time, except upon written approval from the Kentucky Board of Pharmacy; and
   (b) Unless he or she is physically present in that pharmacy for a minimum of ten (10) hours per week or the amount of time appropriate to provide supervision and control.

(3) The pharmacist-in-charge shall be responsible for:
   (a) Quality assurance programs for pharmacy services designed to objectively and systematically monitor care, pursue opportunities for improvement, resolve identified problems as may exist, and detect and prevent drug diversion;
   (b) The procurement, storage, security, and disposition of drugs and the provision of pharmacy services;
   (c) Assuring that all pharmacists and interns employed by the pharmacy are currently licensed;
   (d) Providing notification in writing to the Board of Pharmacy within fourteen (14) calendar days of any change in the:
      1. Employment of the pharmacist-in-charge;
      2. Employment of staff pharmacists; or
      3. Schedule of hours for the pharmacy;
   (e) Making or filing of any reports required by state or federal laws and regulations;
   (f) Responding to the Kentucky Board of Pharmacy regarding identified violations or deficiencies; and
(g) Filing of any report of a theft or loss to:

1. The U. S. Department of Justice Drug Enforcement Agency as required by 21 C.F.R. 1301.76(b);

2. The Department of the Kentucky State Police as required by KRS 315.335; and

3. The board by providing a copy to the board of each report submitted.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Application for Permit to Operate a Pharmacy in Kentucky" Form 1 5/2020 [07/2012];

(b) "Application for Non-Resident Pharmacy Permit", Form 3 5/2020 [07/2012];

(c) "Application for Resident Pharmacy Renewal", Form 2 5/2020 [07/2012]; and

(d) "Application for Non-Resident Pharmacy Permit Renewal", Form 4 5/2020 [07/2012].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Pharmacy, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.
LARRY A. HADLEY, R.Ph.
Executive Director
Kentucky Board of Pharmacy

March 9, 2021
DATE
PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall be held on May 25, 2021 at 9:00 a.m. Eastern Time at the Kentucky Board of Pharmacy, 125 Holmes Street, Suite 300, State Office Building Annex, Frankfort, Kentucky 40601. 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 May 31, 2021. 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: Larry Hadley, 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 Larry.Hadley@ky.gov.
REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Contact person: Larry Hadley
Contact Phone No.: 502-564-7910
Contact email: larry.hadley@ky.gov

1. Provide a brief summary of:
   a. What this administrative regulation does: This administrative regulation establishes
      the requirements for the pharmacist-in-charge at pharmacies permitted by the
      Kentucky Board of Pharmacy.
   b. The necessity of this administrative regulation: KRS 315.191(1)(a) authorizes the
      Board of Pharmacy to promulgate administrative regulations necessary to
      regulate and control all matters relating to pharmacists and pharmacies. KRS
      315.020(1) and KRS 315.0351(7) require applicants for pharmacy permits to
      place a pharmacist in charge as a prerequisite to compounding and dispensing
      privileges granted by the Board of Pharmacy. This regulation dictates the
      responsibilities of a pharmacist-in-charge.
   c. How this administrative regulation conforms to the content of the authorizing statutes:
      This administrative regulation establishes the requirements for the pharmacist-
      in-charge at pharmacies permitted by the Kentucky Board of Pharmacy.
   d. How this administrative regulation currently assists or will assist in the effective
      administration of the statutes: This administrative regulation is essential for dispensing
      and compounding pharmacies to function. Pharmacist-in-charge requirements are
      established by this regulation.

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? The only
      changes are the updated referenced applications.
   b. The necessity of the amendment to this administrative regulation. To update the
      referenced applications.
   c. How the amendment conforms to the content of the authorizing statutes: KRS
      315.191(1)(a) authorizes the board to promulgate administrative regulations pertaining
      to pharmacists and pharmacies. The only amendment made is the update to the
      applications.
   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 by updating the referenced applications.

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 use the updated applications for initial application and renewal.
   b. In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The cost would be to increase the annual permit fee by $25.00, thus the fee will increase from $100.00 to $125.00. This fee increase was already approved with the amendment effective February 4, 2021 to 201 KAR 2:050.
   c. As a result of compliance, what benefits will accrue to the entities identified in question (3): This amendment will update the referenced applications only.

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 is necessary in this regulation. An amendment to 201 KAR 2:050, effective February 4, 2021 increased the annual permit fee by $25.00 for all four referenced applications.

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 pharmacists and sponsors that desire approval for a resident pharmacy permit or a non-resident pharmacy permit.
(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. 315.020, 315.035, 315.0351, 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. The fee increase effectuated by the amendment to 201 KAR 2:050 that applies to applications referenced in this regulation will generate approximately $50,000 in revenue for the Kentucky Board of Pharmacy.

(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? N/A

(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? N/A

(c) How much will it cost to administer this program for the first year? No costs are required to administer this program for the first year.

(d) How much will it cost to administer this program for subsequent years? No costs are required to administer this program for the first year.

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

Revenues (+/-): Approximately $50,000

Expenditures (+/-): 0

Other Explanation:

The amount of revenue will fluctuate depending on the number of pharmacy applications received.
SUMMARY OF MATERIAL INCORPORATED BY REFERENCE

The “Application for Permit To Operate A Pharmacy in Kentucky” is the 2-page initial application form that resident pharmacies are required to file before engaging in the practice of pharmacy. KRS Chapter 315.035 requires a pharmacy to complete a licensure application by the Board of Pharmacy.

Application for Permit To Operate A Pharmacy, Form 1 – 5/2020 has been updated to show the initial application fee increase of $25.00.

The “Application for Resident Pharmacy Renewal” is the 2-page renewal application form that resident pharmacies are required to file annually. KRS Chapter 315.035 requires a pharmacy to annually complete a renewal application by the Board of Pharmacy.

Application for Resident Pharmacy Renewal, Form 2 – 5/2020 has been updated to show the initial application fee increase of $25.00.

The “Application for Non-Resident Pharmacy Permit” is the 4-page initial application form that non-resident pharmacies are required to file before engaging in the practice of pharmacy in Kentucky. KRS Chapter 315.0351 requires a pharmacy to complete a licensure application by the Board of Pharmacy.

Application for Non-Resident Pharmacy Permit, Form 3 – 5/2020 has been updated to show the initial application fee increase of $25.00.

The “Application for Non-Resident Pharmacy Renewal” is the 2-page renewal application form that non-resident pharmacies are required to file annually. KRS Chapter 315.0351 requires a pharmacy to annually complete a renewal application by the Board of Pharmacy.

Application for Non-Resident Pharmacy Renewal, Form 4 – 5/2020 has been updated to show the initial application fee increase of $25.00.
Application For Permit To Operate A Pharmacy In Kentucky

Please print legibly. Make check or money order payable to ‘Kentucky State Treasurer’. 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 Pharmacy __________________________________________________________

Physical Address of Pharmacy ________________________________________________
(Street and Number)
City __________________________ County ____________ Zip ____________

Phone Number __________________ Fax Number __________________________

Email Address _____________________________________________________________

Mailing Address of Pharmacy ________________________________________________
(Street and Number)
City __________________________ State ________ Zip ____________

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

☐ New Facility .......................................................... $125.00

Proposed date of Opening ____________________________________________________
(Filed with Board 30 days in advance of Opening)

☐ Change of Ownership .................................................. $75.00

Date of Proposed Acquisition ____________________________________________
Name of Previous Owner(s) _________________________________________________
(Confirmation statement of previous owner must be attached)

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

Date of Proposed Relocation ______________________________________________
Previous Address _________________________________________________________

☐ Name Change .......................................................... NO CHARGE

Previous Name __________________________________________________________

2. Ownership:
☐ Sole Proprietor ☐ Partnership ☐ Unincorporated Business ☐ Incorporated Business ☐ Other

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

__________________________________________________________________________

__________________________________________________________________________

Form 1-5/2020
3. **Pharmacist-In-Charge (P.I.C.) and Licensed Pharmacist(s):**

<table>
<thead>
<tr>
<th>Name</th>
<th>KY License No.</th>
<th>P.O.A.</th>
<th>Key</th>
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<td>P.I.C.</td>
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(Please indicate by checking the space provided those who have “Power of Attorney” (P.O.A) to order Controlled Substances and/or have been issued keys to the pharmacy.)

Kentucky Pharmacy Regulation 201 KAR 2:205 requires pharmacists-in-charge to notify the Board of all pharmacist personnel changes and changes in pharmacy operating hours.

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

____________________________________________________________________________________________________

5. **Schedule of Hours:**

<table>
<thead>
<tr>
<th>Day</th>
<th>A.M. to P.M.</th>
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<td>Monday</td>
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<td>Sunday</td>
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*Please Indicate if closed for lunch.*

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

6. **Name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy management or staffing (e.g., Pharmacy Services Management Companies or Consultants):**

_____________________________________________________________________________________________________  
_____________________________________________________________________________________________________

7. **Type of Pharmacy (Indicate all that apply):**

<table>
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<tr>
<th>Type</th>
<th>Retail Independent</th>
<th>Retail Chain</th>
<th>Hospital</th>
<th>Nursing Home</th>
<th>Nuclear</th>
<th>Internet</th>
<th>Mail Order</th>
<th>Infusion</th>
<th>Out-of-State</th>
<th>Oxygen</th>
</tr>
</thead>
</table>

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 and 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.

____________________________________________________  
(Signature of Pharmacist-In-Charge)  
(Date)

____________________________________________________  
(Signature of Owner)  
(Date)
APPLICATION FOR RESIDENT PHARMACY RENEWAL

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.

Enclose a check or money order for $125.00, made payable to ‘Kentucky State Treasurer. 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 $100.00 pursuant to 201 KAR 2:050, Section 1(11).

Pharmacy Name _____________________________________________

Address ___________________________________________________________________________________________________

_________________________________________________________________________________________________

Telephone Number__________________ Fax Number__________________ Email Address____________________________

Date of last controlled substance inventory ________________________________________________________________

DEA Registration Number ___________________________ Expiration Date ___________________________

Ownership:
☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ LLC ☐ Other

Name and title for each owner/officer, including office and professional designation: (Use a separate piece of paper if necessary)

_________________________________________________________________________________________________

_________________________________________________________________________________________________

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. ____________
**Type of Pharmacy** (Indicate by circling all that apply):

Retail Independent  
Retail Chain  
Hospital  
Charitable  
Infusion  
Hospital-Ambulatory  
Nursing Home  
Nuclear  
*Internet  
Mail Order  

* This must be circled if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is circled, VIPPS accreditation will be verified with the NABP.

**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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>License/Registration Number</th>
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Name, title and address of each non-pharmacist with keys to the pharmacy:

__________________________  __________________________

*Please submit the name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy operations, management or staffing (eg. Pharmacy Services Management companies or consultants) on a separate sheet of paper.

1. Does pharmacy ship medications outside of Kentucky?  
   _____YES  
   _____NO

2. Do you perform sterile compounding?  
   _____YES  
   _____NO

3. Do you perform nonsterile compounding?  
   _____YES  
   _____NO

4. Are you permitted in other states?  
   _____YES, please list below  
   _____NO
5. Have you had a Pharmacy license/permit surrendered to or fined, suspended, probated, or revoked by any Board of Pharmacy which you have not previously reported to this Board?

   _____Yes, attach an explanation   _____NO

6. 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 and 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.

_________________________________________  ______________________________
Signature of Owner                       Date
Application For Non-Resident Pharmacy Permit

Please print legibly. Make check or money order payable to ‘Kentucky State Treasurer’. Mail completed application to the above address. All applicable entries must be completed. Please use the checklist of required documentation at the end of this application. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

1. Name of Pharmacy ______________________________________________

Physical Address of Pharmacy __________________________________________

City ___________________________ State ______________ Zip ______________

Phone Number ___________________ Toll Free Number __________________ Fax Number __________________

Website Address __________________________ Email Address __________________________

Mailing Address of Pharmacy __________________________________________

City ___________________________ State ______________ Zip ______________

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

☐ New Pharmacy ........................................................... $125.00
   Proposed date of Opening __________________________
   (Filed with Board 30 days in advance of Opening)

☐ Change of Ownership .................................................. $75.00
   Date of Proposed Acquisition __________________________
   Name of Previous Owner(s) ______________________________
   (REQUIRED DOCUMENT: Confirmation statement of previous owner OR legal documentation of ownership change)

☐ Change of Address/Location ........................................... $75.00
   Date of Proposed Relocation __________________________
   Previous Address _________________________________

☐ Name Change ........................................................... NO CHARGE
   Previous Name _________________________________
2. **Ownership:**

- [ ] Sole Proprietor  
- [ ] Partnership  
- [ ] Unincorporated Business  
- [ ] Incorporated Business  
- [ ] Other

On a separate sheet of paper, please provide the following information for each owner/officer, including professional designation (e.g. Pres. John Jones, M.D.):

- Name and Title
- Address (Business and Home)
- Phone Number (Business and Home)
- Social Security Number
- Date of Birth

3. **Pharmacist-In-Charge (P.I.C.):**

<table>
<thead>
<tr>
<th>Name</th>
<th>Kentucky License No.</th>
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<tr>
<td>P.I.C.</td>
<td>____________________</td>
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List the names and Kentucky license numbers of any staff pharmacists licensed with Kentucky:

<table>
<thead>
<tr>
<th>Name</th>
<th>Kentucky License No.</th>
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(Use a separate piece of paper if necessary)

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

**Senate Bill 88 amends KRS 315.0351 to require out-of-state pharmacies who are providing prescription medications to citizens of the Commonwealth to have a pharmacist-in-charge who holds a Kentucky pharmacist license. This Kentucky licensed pharmacist may be any employee pharmacist of the pharmacy.**

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

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

5. **Schedule of Hours:**

- Monday . . . _______ A.M. to _______ P.M.
- Tuesday . . . _______ A.M. to _______ P.M.
- Wednesday . . _______ A.M. to _______ P.M.
- Thursday . . . _______ A.M. to _______ P.M.
- Friday . . . _______ A.M. to _______ P.M.
- Saturday . . . _______ A.M. to _______ P.M.
- Sunday . . . _______ A.M. to _______ P.M.

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

6. **Does pharmacy currently utilize an automated data processing system?**

- [ ] Yes*  
- [ ] No

*If yes, identify the source for: Hardware ____________________________ Software ____________________________

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Form 3 - 5/2020
7. TYPES OF PHARMACY (INDICATE BY CIRCILING ALL THAT APPLY):

Retail Independent  Retail Chain  Hospital  Nursing Home  Nuclear
* Internet  Mail Order  Infusion  Out-of-State  Oxygen

* This must be circled if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is circled, Section 8 must be completed.

8. Is the pharmacy VIPPS accredited?  __________Yes  __________No

9. Does the pharmacy dispense any prescriptions to citizens of the Commonwealth of Kentucky that have been referred to the pharmacy, in whole or in part, by an outside agent (e.g. internet broker)?  __________Yes*  __________No

*If yes: Approximately how many anticipated or actual prescriptions dispensed to citizens of the Commonwealth of Kentucky per calendar month are referred to the pharmacy by agent(s).

List the name, address, phone number, and email address of all agents:

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<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
<th>EMAIL ADDRESS</th>
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(Use a separate piece of paper if necessary)

10. Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky?  __________Yes*  __________No

*If yes: On a separate sheet of paper, please provide the following information for all physicians:

❖ Name
❖ Business Address
❖ Business Phone
❖ Email address
❖ DEA number
❖ State(s) of licensure
❖ Date of Birth
❖ Social Security number

11. 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 a separate piece of paper if necessary)
12. List the methods of deliver services (e.g. USPS, UPS, DHL, FedEx, etc) utilized to deliver prescriptions to citizens of the Commonwealth of Kentucky and the percentage of time each service is utilized in Kentucky.

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<th>Delivery Service Utilized</th>
<th>Percentage of Time Utilized</th>
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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 and 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.

Signature of Pharmacist-in-Charge ________________________________ Date ____________

I hereby certify that the above Application for Non-Resident Pharmacy Permit was signed, subscribed and sworn to before me this _________ day of ____________, 20__

Signature____________________________________________________

My Commission Expires______________________________ State of ____________

Signature of Owner ________________________________ Date ____________

I hereby certify that the above Application for Non-Resident Pharmacy Permit was signed, subscribed and sworn to before me this _________ day of ____________, 20__

Signature____________________________________________________

My Commission Expires______________________________ State of ____________

REQUIRED DOCUMENTATION MUST BE ENCLOSED:

[FOR INITIAL APPLICATIONS ONLY]

- Completed application
- Copy of Resident Pharmacy Permit
- Copy of Last Inspection Report
- Copy of DEA Registration
- Completed Attached License Verification Form
- Sample Label of any Pharmacy Label used to ship Controlled and Non-Controlled Substances 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
Application For Non-Resident Pharmacy Permit Renewal

Please print legibly. Make check or money order for $125 made payable to ‘Kentucky State Treasurer’. Mail completed application including the required original signatures and mail to the above address. All applications must be received in the Board office by June 30th.

1. Name of Pharmacy ________________________________________________

Physical Address of Pharmacy ________________________________________________
(Street and Number)  
City ____________________________________________ State __________ Zip __________

Phone Number _______________ Toll Free Number _______________ Fax Number _______________

Website Address __________________________ Email Address __________________________

Mailing Address of Pharmacy __________________________________________
(Street and Number)  
City ____________________________________________ State __________ Zip __________

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.

DEA Registration No._________________________ Expiration Date:____________________

Ownership:
☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ LLC ☐ Other

Name and title for each owner/officer, including office and professional designation:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

2. Pharmacist-In-Charge (P.I.C.):

Name __________________________________ Kentucky License No. ______________
City of Residence ______________

P.I.C. __________________________________

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

Senate Bill 88 amends KRS 315.0351 to require out-of-state pharmacies who are providing prescription medications to citizens of the Commonwealth to have a pharmacist-in-charge who holds a Kentucky pharmacist license. This Kentucky licensed pharmacist may be any employee pharmacist of the pharmacy.

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

Kentucky Permit Number

KENTUCKY BOARD OF PHARMACY
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601

Phone (502) 564-7910 Fax (502) 696-3806
4. **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.
- **Tuesday:** ________ A.M. to ________ P.M.
- **Wednesday:** ________ A.M. to ________ P.M.
- **Thursday:** ________ A.M. to ________ P.M.
- **Friday:** ________ A.M. to ________ P.M.
- **Saturday:** ________ A.M. to ________ P.M.
- **Sunday:** ________ A.M. to ________ P.M.

5. **TYPES OF PHARMACY (INDICATE BY CIRCLING ALL THAT APPLY):**

- Retail Independent
- Retail Chain
- Hospital
- Nursing Home
- Nuclear
- Internet
- Mail Order
- Infusion
- Out-of-State
- Oxygen

* This must be circled if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, Internet broker or shipper]. If Internet is circled, VIPPS accreditation will be verified with the NABP and Section 7 must be completed.

6. **Does the pharmacy dispense any prescriptions to citizens of the Commonwealth of Kentucky that have been referred to the pharmacy, in whole or in part, by an outside agent (e.g. internet broker)?**

   - Yes*
   - No

   *If yes: Approximately how many anticipated or actual prescriptions dispensed to citizens of the Commonwealth of Kentucky per calendar month are referred to the pharmacy by agent(s).

   List the name, address, phone number, and email address of all agents:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
<th>EMAIL ADDRESS</th>
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   (Use a separate piece of paper if necessary)

7. **Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky?**

   - Yes*
   - No

   *If yes: On a separate sheet of paper, please provide the following information for all physicians:

   - Name
   - Business Address
   - Business Phone
   - Email address
   - DEA number
   - State(s) of licensure
   - Date of Birth (Month and Year only)
   - Social Security number (optional)

8. **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 a separate piece of paper if necessary)

9. **Do you perform sterile compounding?**

   - Yes
   - No

10. **Do you perform nonsterile compounding?**

    - Yes
    - No

11. **Are you permitted in other states?**

    - Yes, please list below
    - No

12. **Have you had a Pharmacy license/permit surrendered to or fined, suspended, probated, or revoked by any Board of Pharmacy which you have not previously reported to this Board?**

    - Yes, attach an explanation
    - No
Please include a copy of your most recent pharmacy inspection with this application.

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 and 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.

_________________________________________  _______________________
Signature of Owner                                      Date