PENNSYLVANIA STATE BOARD OF PHARMACY

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PO Box 2649
Harrisburg, PA 17105-2649

Courier Address: (UPS, FED-EX, etc.)
PA Dept of State, Bureau of Professional and Occupational Affairs
Attn: State Board of Pharmacy
2 Technology Park
Harrisburg, PA 17110-2919

CENTRAL PROCESSING CENTER PHARMACY APPLICATION (#854 112, Rev. 4/15)

This application is to be used for a pharmacy that intends to operate strictly as a "Central processing center" as defined in Board Regulation Section 27.1. If a pharmacy will be involved in the preparation and packaging of medication, please use Pharmacy Application #854 106.

Type of Transaction Requested (Check One)

☐ Proposed Central Processing Center Pharmacy - $125.00 Fee

☐ Change in Location of an Existing Central Processing Center Pharmacy - $125.00 Fee

☐ Conversion of an Existing Pharmacy to Strictly a Central Processing Center Pharmacy - $125.00 Fee

☐ Remodel of an Existing Central Processing Center Pharmacy - $125.00 Fee

Make check or money order payable to the "Commonwealth of PA." Fees are NOT refundable nor transferable. Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

Name of pharmacy:_____
(The name on the permit, label and sign, if used, must be identical)

If this is an existing pharmacy, please note pharmacy permit number:_____

(New) Address of pharmacy:_____
Street

_____, PA_____
City Zip Code

Federal Employer Identification Number (FEIN):_____

Contact person's name:_____

Contact person's phone number:_____

Contact person's fax number:_____

Contact person's address:_____
Street

_____
City State Zip Code

Contact person's e-mail address:_____

Expected date the pharmacy will be ready for inspection:_____
(Month/Day/Year)

Please complete the following sections with regard to ownership of this pharmacy.

Full name of the pharmacy's owner:_____

The owner is a (check one):

☐ Corporation - List the names of the director and principal officers, the offices they hold, their home addresses and the percentage of stock owned in the spaces below.
☐ Limited Liability Company (LLC) - List the officers/members, the offices they hold (if any), their home addresses and the percentage of interest owned in the spaces below.
☐ Hospital - List the name of the hospital administrator and their home address along with the names of the hospital's principal officers, the offices they hold, their home addresses, and the percentage of interest owned in the spaces below.
☐ Nursing Home - List the name of the nursing home administrator and their home address along with the names of the nursing home's principal officers, the offices they hold, their home addresses, and the percentage of interest owned in the spaces below.
☐ Individual(s) - List the name(s) of the individual owner(s), their pharmacist license number(s) (if any), their home addresses, and the percentage of ownership in the spaces below.
☐ Limited Partnership - List the names of the principal officers (if any) and the names of the individuals overseeing the operation of the limited partnership, the offices they hold (if any), their home addresses and the percentage of interest owned in the spaces below.
☐ Other (specify)_____ - List the names of the director and the principal officers, the offices they hold, their home addresses and the percentage of interest owned in the spaces below.

If additional space is required, please provide the requested information on an 8 ½" X 11" sheet of paper and attach it to this application.

_____
_____
_____
_____
_____
_____
_____

If applicable, please provide the following information:

Names of **stockholders/interest holders** with more than 10% Home address Percentage of stock/interest

_____
_____
_____
_____

List the type of patient that this pharmacy serves (ex. mail order customers, retail customers, etc.)_____

_____

Does a medical practitioner have any proprietary interest in the pharmacy? ☐ Yes ☐ No
If "Yes", indicate the percentage of interest:_____%
If "Yes", please provide information regarding the involvement of the medical practitioner in the direction, control and daily operation of the pharmacy.

Are there any pending indictments of any nature or any alleged violations of the law governing the practice of pharmacy against any of the individuals listed on this application or have any of them been convicted of any crimes within the past ten years? ☐ Yes ☐ No
If yes, please give details on an attached sheet of paper.

Is this pharmacy located in a health care facility as defined in the "Health Care Facilities Act", is it or will it be periodically inspected by the Department of Health in accordance with the standards in the Pharmacy Act and Board Regulations, AND will the Department of Health forward copies of their inspection reports to the Board of Pharmacy office? ☐ Yes ☐ No
If you answered "Yes", please provide the following:

Name of health care facility:_____

Address of health care facility:_____

Type of health care facility (i.e. nursing home, hospital, etc.):_____

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

The prescription area of this pharmacy has all of the equipment and facilities that are required in the Pharmacy Act and Rules and Regulations and in the event of loss or breakage of any item, it will be replaced immediately.

I agree to display the pharmacy permit conspicuously and I understand that the pharmacy permit may not be transferred.

I agree to notify the Board immediately in the event that I should change location, change ownership, change title, change pharmacist manager, remodel or discontinue this pharmacy. I agree to notify the Board in the event of a fire or flood or if the pharmacy permit has been lost or misplaced.

I agree, as a non-pharmacist owner, not to exercise control over the professional activities of the licensed pharmacists under my employ. I will not be involved in any pharmacy-related activity which requires the professional judgment of a licensed pharmacist.

_____ _____
Signature of the Registered Pharmacist Manager Date

_____
Printed Name of Pharmacist Manager

License Number:__RP-_____

AND _____ _____
Signature of Pharmacy Owner's Authorized Representative Date

Title:_____

Printed Name:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Does the central processing center have adequate space to perform the functions taking place there? Yes ☐ No ☐

2. Will there be a telephone in the prescription area? Yes ☐ No ☐

3. Are restroom facilities located reasonably close to, but outside of the prescription area? Yes ☐ No ☐

Please review Question 4 and check "N/A" (not applicable) if Question 4 does not apply: N/A ☐

4. For pharmacies located within a retail establishment whose business hours differ:
   a. Will the pharmacy be securely sealed off from the retail establishment? Yes ☐ No ☐
   b. Will the barrier device which seals off the pharmacy reach from floor to ceiling? Yes ☐ No ☐
   c. Will this barrier device be impenetrable by hand or the use of a reach extender? Yes ☐ No ☐

5. Does the central processing center have the equipment, supplies and an adequate reference library necessary to engage in centralized prescription processing? Yes ☐ No ☐

6. Does this central processing center have a contract with or the same owner as the originating pharmacy and the delivering pharmacy? Yes ☐ No ☐

7. Do operating policies and procedures exist which include, but are not limited to, an audit trail that records and documents the central prescription process and the individuals accountable at each step in the process for complying with Federal and State laws and regulations including recordkeeping? Yes ☐ No ☐

8. Do all of the pharmacies involved in centralized prescription processing share a common electronic file? Yes ☐ No ☐

9. The Board has the same standards for security for all pharmacies. Is this pharmacy located in a building with other occupants? Yes ☐ No ☐
   If your response is "Yes", please also respond to the following questions:
   a. Will the pharmacy be securely sealed off from the other occupants? Yes ☐ No ☐
   b. Will the barrier device which seals off the pharmacy reach from floor to ceiling? Yes ☐ No ☐
   c. Will this barrier device be impenetrable by hand or the use of a reach extender? Yes ☐ No ☐

10. For an existing pharmacy that is converting the pharmacy's operation to strictly that of a central processing center, please provide information on the disposition of the non-proprietary drugs (i.e. sold to another pharmacy, returned to the wholesaler, destroyed, etc.) **If the drugs were sold to another pharmacy, please also provide the name and permit number of that other pharmacy.**

_____

_____

_____

Please draw a skeleton sketch showing the **proposed** floor plans for the central processing center. Failure to provide information on the **entire** pharmacy may result in a delay in the processing of your application. Please provide detailed information on the placement of any work counters and the bathroom as well as the dimensions of the central processing center. A permit may be issued for a self-contained pharmacy having an entrance into an adjoining store that owns the pharmacy or is otherwise affiliated with it. Blue prints are not accepted in lieu of this sketch. If more space is required, please attach additional 8 ½" X 11" sheets of paper to this application.

*Board Regulation Section 27.1 defines "Prescription area" as "That area of the pharmacy used for compounding, legend drug storage and other activities necessary to the practice of pharmacy. The term does not include waiting counters or display space attached to the waiting counters."

FOR REMODELS ONLY

If this application is being submitted for a **remodel** of an existing central processing center, please also:

1. Provide on an 8 1/2" x 11" sheet of paper the current floor plans of the central processing center (i.e. prior to any construction) and
2. Complete the section below.

List the precautions taken to protect the health and safety of the professionals, employees, and the public during the continuing operation of the pharmacy while the pharmacy is being remodeled. Please include information on procedures that will be put into place to prevent unauthorized access to confidential information. Please also indicate if a Pennsylvania-licensed pharmacist will be present during construction.

Please Note the Following Information:

Refer to the Board Regulations for additional information on centralized prescription processing.

New pharmacy applicants are permitted to open when the permit number has been assigned. The permit does not have to be received and displayed prior to the pharmacy opening. The permit must be posted upon receipt.

A proposed pharmacy that fails the inspection will be required to pay $115.00 for re-inspection. It will be the responsibility of the new business to notify the Board office in writing when the pharmacy is ready for re-inspection.

Correcting any deficiency or violation noted on the inspection report for a change in location, remodel or the conversion of an existing pharmacy's operation to strictly that of a central processing center will be the responsibility of the owner. The Board will grant a period of not more than thirty days to correct the deficiency/violation. A $115.00 re-inspection fee must be submitted to the Board office along with notification in writing that all deficiencies/violations have been corrected. Failure to do so will be just cause for the Board to take other appropriate action.

It is your responsibility to maintain a copy of this and all documents submitted to the Board or received from the Board for your future reference.

The pharmacy permit number will not change with the processing of this application for a change in location, a remodel or the conversion of an existing pharmacy's operation to strictly that of a central processing center.

If there are any discrepancies with the application, information on the discrepancies will be sent to the pharmacy's contact person. Once the application is in order, the Board office staff will notify the pharmacy's contact person that the application has been accepted.

If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee.

Helpful Information

Before submitting your application, please refer to the following helpful hints. Keep in mind that original application pages, not photocopies nor faxed copies, must be submitted along with the application fee.

Page One:

1. Have you provided the pharmacy's correct name, pharmacy permit number (for existing pharmacies) and address?
2. Have you provided the FEIN?
3. Have you provided complete information for the contact person?
4. Have you provided the inspection ready date in month/day/year format?

Page Two:

1. Have you provided the name of the owner? If an entity owns the pharmacy permit, list the entity's name - not the name of any stockholders/interest holders.
2. Have you indicated the type of ownership?
3. Have you provided the director/officer/member information that was requested?
4. Have you provided **home** addresses, where requested?
5. Have you provided the percentage of stock/interest owned or held by the individuals who are listed on this page? "Zero" is an acceptable number, if accurate.
6. Have you listed the stockholders or interest holders with more than 10%, the home addresses and percentage of stock/interest?
7. Have you listed the types of patient that the pharmacy serves?
8. Have you answered the two questions located near the bottom of the page and provided any additional information as directed?

Page Three:

1. Have you answered the question at the top of the page and provided additional information if your response to the question was "Yes"?
2. Has the pharmacist manager signed, dated, printed his name and listed his license number in the appropriate spaces?
3. Has the owner's authorized representative signed, dated, listed his/her title and printed his/her name in the appropriate spaces?
4. Are you submitting the **original** application page three?

Page Four:

1. Have you answered questions one through nine?
2. If this is an existing pharmacy that is converting to a central processing center, have your provided information on the disposition of the non-proprietary drugs?

Page Five:

1. Are the floor plans on 8 ½" x 11" paper? The Board is unable to accept larger floor plans as they cannot be microfilmed/scanned.
2. Floor plans:
   Have you provided information on the placement of any work counters?
   Have you provided dimensions of the pharmacy?
   Is there an indication of the location of the bathrooms?
   Are all walls shown as well as placement of the doors?
   Are the different rooms identified?
   Are the fixtures shown in each room?

Page Six:

1. **If** this is a remodel of an existing central processing center, have you provided current floor plans (prior to any construction) on a separate 8 ½" x 11" sheet of paper?
2. **If** this is a remodel of an existing central processing center, have you provided information on the precautions and security measures that will be taken during construction?