Washington State Department of Health

Pharmacy License Application Packet

Contents:

1. 690-159 ..... Contents List/Mailing Information .....1 page
2. 690-160 ..... Application Instructions Checklist .....2 pages
3. 690-152 ..... Pharmacy License Application.....3 pages
4. 690-249 ..... NPLEx Account Activation .....2 pages
5. 690-222 ..... NPLEx Exception Request .....2 pages
6. 631-020 ..... Prescription Monitoring Program
   Certification of No Dispensing of Controlled Substances..... 1 Page
7. RCW/WAC and Online Website Links.....1 page

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Pharmacy Quality Assurance
Commission Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application Instructions Checklist

When your application for pharmacy license is received by the Department of Health, you will be notified in writing of any outstanding documentation needed to complete the application process.

Indicate type of application—New, change of ownership, change of location, or name change.

- **New**—First time requesting a pharmacy license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed pharmacy.
- **Change of Location**—Changing the location address of the pharmacy. Include your current license number.
- **Name Change Only**—List your current facility name.

☐ **Check One:**
Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **Application Fees:** Check all that apply; pharmacy location, controlled substance act, ancillary utilization (complete additional application), or differential hours (complete additional application). Fees are non-refundable. You can check the online **fee page** for current fees.
Note: If you are applying for ancillary utilization you have to complete the ancillary plan and send it in with the application.

☐ **1. Demographic Information:**

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI#'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/ Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Phone and Fax Numbers: Enter the owner's phone and fax number.

Email and Web Address: Enter the owner's email and agency Web addresses, if they have them.

Facility/Agency Name: Enter the agency's name as advertised on signs, brochures or Web sites.

Physical Address: Enter the agency's physical street location including city, state, zip code, and county.

Email address: Enter the agency's email address if available.

Phone and Fax Numbers: Enter the agency's phone and fax number.

Mailing Address: Enter the agency's mailing address, if different than physical address.

☐ **2. Facility Information:**

Type of Pharmacy: Please check which type of pharmacy you are applying for; community retail, hospital, jail, long-term care, mail-order, nuclear, parenteral, or internet (include web address).

Hours Pharmacy will be open: Enter hours pharmacy will be open Monday-Friday, Saturday, Sunday, and any holiday hours that will be open.

Drug Enforcement Administration (DEA) Registration Number: Enter the federal DEA registration number if dispensing controlled substances. Enter "pending" if the pharmacy has not been issued its DEA registration number.

Background Questions: Check yes or no and if you check yes, list and explain on a separate sheet of paper.

Pharmacist in Charge: Enter pharmacist name, license number, and date of appointment.

☐ **3. Contact Information:**

Enter name, title, phone number, fax number, and email address.

☐ **4. Additional Information:**

Corporation information: Enter date of incorporation, corporate number, and state of corporation.

Legal Owner: List the names, titles, addresses, and phone numbers of the corporate officers, partners, members, and managers. Attach additional completed pages if you need more space.

Change of Ownership Information: List the previous legal owner name, previous name of facility, previous license number, and effective date of ownership change.

List of Pharmacists: List all pharmacists working in your pharmacy. Attach additional completed pages if you need more space.

☐ **Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

Washington State Department of Health

Date Stamp Here

Fees (Check all that apply)

- ☐ Pharmacy Location .....Fee
- ☐ Controlled Substance Act.....Fee
- ☐ Ancillary Utilization .....Fee
  (Complete additional application)
- ☐ Differential Hours .....Fee
  (Complete additional application)

Check the online **fee page** for current fees
All application fees are nonrefundable.

Revenue: 0262010000

Pharmacy License Application

This is for: ☐ New ☐ Change of Ownership ☐ Change of Location – Current License #_____
☐ **Name Change Only** – Current Facility Name _____

Check One

- ☐ Association
- ☐ Corporation
- ☐ Federal Government Agency
- ☐ Limited Liability Company
- ☐ Limited Liability Partnership
- ☐ Limited Partnership
- ☐ Municipality (City)
- ☐ Municipality (County)
- ☐ Non-Profit Corporation
- ☐ Partnership
- ☐ Sole Proprietor
- ☐ State Government Agency
- ☐ Tribal Government Agency
- ☐ Trust

1. Demographic Information

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email Address		Web Address:	
Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip Code	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email Address:			
Mailing Address (If different than physical address)			
City	State	Zip Code	County

2. Facility Information

Type of Pharmacy

☐ Community/Retail ☐ Hospital ☐ Jail ☐ Long-term Care (LTC)
☐ Mail-Order ☐ Nuclear ☐ Parenteral ☐ Internet ☐ Compounding

Pharmacy Hours—Indicate the hours the pharmacy will be open

Monday–Friday	Saturday	Sunday	Holidays

Drug Enforcement Administration (DEA) Registration Number

DEA Number: _____

Background Questions Yes No

1. Have any applicants, partners, or managers had a suspension, revocation, or restriction of a professional license? ..... ☐ ☐
   If yes, list and explain on a separate sheet of paper.
2. Have any applicants, partners, or managers been found guilty of a drug or controlled substance violation? ..... ☐ ☐
   If yes, list and explain on a separate sheet of paper.

Pharmacist in Charge

Pharmacist in Charge	License Number	Date of Appointment

3. Contact Information

Contact Person Name / Title	Phone (enter 10 digit #)	Email Address
Contact Person Name / Title	Phone (enter 10 digit #)	Email Address

4. Additional Information

Date of Incorporation	Corporate Number	State of Corporation

Legal Owner Information–attach additional completed pages if you need more space.

List names, addresses, phone numbers, and titles of corporate officers, partners, members and managers.

Name	Address	Phone (enter 10 digit #)	Title

Change of Ownership Information

Previous Name of Legal Owner		
Previous Name of Facility	Previous Pharmacy License #	Effective Date of Ownership Change

List all Pharmacist–attach additional completed pages if you need more space.

Name	License #

Signature

I certify I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify the information herein submitted is true to the best of my knowledge and belief.

Signature of Owner/Authorized Representative of Pharmacy

Date

Print Name

Print Title

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Washington State Department of Health

Pharmacy Quality Assurance
Commission
PO Box 47877
Olympia, WA 98504-7863
360-236-4700

Washington State Methamphetamine Precursor Electronic Tracking System NPLEx Account Activation

In 2010 the Washington Legislature passed **RCW 69.43.110** to restrict the sale and purchase of non-prescription products containing ephedrine, pseudoephedrine, and phenylpropanolamine or their salts or isomers, or salts of isomers.

The law:

- Requires pharmacies to keep products containing methamphetamine precursors behind the counter where the public is not permitted or in a locked display case where it is not accessible to customers without assistance;
- Requires the retailer to record the name and address of the purchaser, the date and time of the sale, the name and the initials of the person conducting the transaction, the name of the product sold, and the total quantity in grams of the precursors being sold;
- Requires the customer to electronically or manually sign a record of any transactions when purchasing methamphetamine precursors;
- Updates the sales limits to match the federal restrictions-daily sales limit of 3.6 grams per purchaser and prohibits a purchaser from buying more than nine grams during a 30-day period; and
- Requires the Pharmacy Quality Assurance Commission to implement a real-time electronic sales tracking system.
    * Rules: **WAC 246-869-070 through 120**

Note: If your pharmacy sells ephedrine, pseudoephedrine, and/or phenylpropanolamine over the counter, you will need to set up an account to access and report to the National Precursor Log Exchange (NPLEx) by visiting: **https://nplex.appriss.com**.

Notification to the commission of Pharmacy
Opting Out of Electronic Reporting - NPLEx

Please provide the information requested below (print or type.)

Name of Pharmacy		Washington Pharmacy License Number	
Address	City	State	Zip Code
Email Address	Phone (enter 10 digit #)		
Name of Pharmacy Responsible Manager	License Number of		
Name of Person Completing form	Signature and Date		

By signing this form I certify that the aforementioned pharmacy:

- ☐ Does not currently sell, transfer, or to otherwise furnish over-the-counter ephedrine, pseudoephedrine, and/or phenylpropanolamine products.
- ☐ Currently sells, transfers, or otherwise furnishes ephendrine, pseudoephedrine, and/or phenylpropanolamine containing products by prescriptions only.
- ☐ Meets the exemption in **RCW 69.43.110** and has submitted documentation to show good cause why compliance with the electronic reporting would be a significant hardship. A paper log is being maintained pending commission approval.

Additional comments:

Washington State Department of Health

Pharmacy Quality Assurance Commission
PO Box 47877
Olympia, WA 98504-7863
360-236-4700

Date Stamp Here

Washington Methamphetamine Precursor Electronic Retail Sales Tracking System

Request for Exemption

Revised Code of Washington 69.43.110 provides an exemption from the Washington Methamphetamine Precursor Electronic Retail Sales Tracking System (NPLEx) reporting requirements for retailers that can show good cause why they cannot comply. Retailers who believe they are eligible under this provision may apply for an exemption with the Washington State Pharmacy Quality Assurance Commission. To request an exemption from compliance, complete **all** of the following information along with the signature of the retailer or person authorized by the retailer. The commission will review the request for exemption and will grant or deny the request within 15 business days from receipt.

Good cause conveys must show significant hardship to comply as prescribed by law. What constitutes a good cause will be determined on a case-by-case basis. Good cause, includes but is not limited to, situations where the installation of the necessary equipment to access the system is unavailable or cost prohibitive to the retailer.

Credential Type:

☐ Pharmacy	Credential Number / DEA CMEA Cert ID _____	_____
☐ Itinerant Vendor	Credential Number / DEA CMEA Cert ID _____	_____
☐ Shopkeeper (endorsement)	UBI Number / DEA CMEA Cert ID _____	_____

Demographic Information:

Legal Owner/Operator Name			
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)	Fax (enter 10 digit #)		
Email Address	Web Address		

Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip Code	County
Facility phone (enter 10 digit #)	Fax (enter 10 digit #)		
Mailing Address (if different than physical address)			
Email Address	Web Address		

This is a request for an:

☐ Original Exemption Request — Length of Exemption (not to exceed 180 days): _____

☐ Extension Request — Length of Exemption (not to exceed 180 days): _____

Justification for Exemption:
(include additional sheets and supporting documentation if needed to show good cause)

Signature

I attest that I have received, read, understood, and agree to comply with state law and rule regulating this license category. I also attest that the information herein submitted is true to the best of my knowledge and belief. I also understand that the business is required to keep a written log of all purchase transactions involving restricted products to include the following:

Date and time of purchase, product description; quantity sold (total grams, number of boxes, etc.); purchaser's full name, date of birth, current address, form of identification used to establish age; identification form number; purchaser's signature and initials of the person making the sale.

Signature of Owner/Authorized Representative

Date (mm/dd/yyyy)

Print Name

Print Title

Please send request to the address above.

Prescription Monitoring Program
PO Box 47852 | Olympia, WA 98504-7852
Telephone: (360) 236-4806
Fax: (360) 236-2901

Certification of No Dispensing of Controlled Substances

Please provide the information requested below. (Print or Type) Use full name not initials.		
Name of Pharmacy		Washington Pharmacy License Number
Pharmacy DEA Number		Street Address
City	State	Zip Code
Email Address		Area Code and Telephone Number
Name of Pharmacy Responsible Manager		License Number of Responsible Manager (Include State of Licensure)

By signing this form I certify that:

- **My pharmacy does not currently deliver any drugs covered by the program (schedule II, III, IV, or V controlled substances or any other drugs added by the Pharmacy Commission) to ultimate users who have a Washington State address.**
- **If our business practice changes regarding dispensing drugs covered by the program to ultimate users with a Washington State address, we will notify the Washington State Department of Health and begin data submission as required in RCW 70.225.**
- **My pharmacy will resubmit this form every year with our pharmacy license renewal in order to re-certify that the pharmacy does not deliver any drugs covered by the program to ultimate users who have a Washington State address.**

Signature:	Date:

Additional Comments:

If approved, this form removes the requirement of zero reporting to the WA PMP until your next licensing renewal date, unless you begin to dispense controlled substances to ultimate users who have a Washington State address.

For Department Use Only			
Date Received	☐ Approved ☐ Disapproved	Director or Designee Signature	Date of Action
Notes:			

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Uniform Controlled Substance Act, RCW 69.50

Administrative procedures and requirements, WAC 246-12

Standards of Professional Conduct, WAC 246-16

Pharmacy Laws, RCW 18.64

Pharmacy Rules, WAC 246-869

Pharmaceutical Services-Extended Care Facility, WAC 246-865

Hospital Standards, WAC 246-873

Nuclear Pharmacies and Pharmacist, WAC 246-903

Pharmacy-Ancillary Personnel, WAC 246-901

Legend and Prescription Drugs, RCW 69.41

Precursor Drugs, RCW 69.43

Pharmaceutical-Precursor Substance, WAC 246-889

Regulations Implementing the Uniform Controlled Substance Act, WAC 246-887

Prescription Monitoring Program Laws, RCW 70.225.020

Prescription Monitoring Program Rules, WAC 246-470

On-Line

AIDS Training Resources, Reference Page

Pharmacy Quality Assurance Commission, Web Page