

## **INSTRUCTIONS FOR COMPLETING THE 340B REGISTRATION FORM**

(for use by FP entities authorized under Title X only)

While an organization may be eligible to participate in the 340B Program by virtue of its status (i.e., receiving a grant from an eligible program), it must notify the Office of Pharmacy Affairs (OPA) of its intention to participate by completing and submitting a signed original of the "340B Program Registration Form for Covered Entities." Once the OPA receives, verifies, and processes this information, the entity will be eligible to purchase pharmaceuticals at the 340B price beginning the next calendar quarter.

**In order to allow sufficient time for verification and processing of the information on the registration form, the quarterly deadlines for submission of registration forms to OPA are December 1 to become effective as a participating covered entity for the quarter beginning January 1; March 1 to become effective as a participating covered entity for the quarter beginning April 1; June 1 to become effective as a participating covered entity for the quarter beginning July 1; and September 1 to become effective as a participating covered entity for the quarter beginning October 1.** If your submission is close to the deadline, you are advised to FAX the form to **301-594-4982** and mail the original to the address listed below.

NOTE ON SIGNATURES – the Registration Form must be signed by a responsible representative of the funded grantee. Forms that are signed by an individual that OPA determines is not an acceptable representative will not be processed. If you are in doubt regarding the acceptability of a signature, please contact OPA prior to submission of your registration form. Please include the title, telephone number, and e-mail address of the individual who is signing.

CONTACT – Please provide the name, title, telephone number, FAX number, and e-mail address of the individual in your entity who will be the point of contact for the 340B program.

NOTE ON SHIPPING ADDRESSES – complete this section ONLY if your pharmaceuticals will be shipped to an address that is different from the covered entity address. However, **do NOT use this section to provide information for a contracted pharmacy arrangement.** Use the form found at this [link](#) for contracted pharmacy information.

**The registration process is not complete unless the registration form has been completed in its entirety (all requested information is filled in on the form) and the original, signed copy is received as directed below.**

Accurate information on the entity should always be reflected on the OPA website. It is both the covered entity and the grantee's responsibility to notify OPA of any changes in writing.

Once your form has been processed, the OPA will notify you (at the e-mail address that you provide on the Program Registration Form) of your effective date in the 340B Program and provide you with your 340B identification number, a unique number that OPA assigns to each covered entity. Please use this number in all correspondence to OPA. This is the number used by manufacturers, wholesalers, and others to search the OPA database to verify your participation in the 340B program. It is the entity's responsibility to tell its wholesaler or manufacturer that it is registered for 340B prices when it places an order. You may view the information for your entity on the [OPA database](#) by entering the 340B ID number in the field labeled "340B ID." New additions to the database are closed two weeks prior to the start of the quarter. If you do not see your entity listed on the database, you are NOT registered.

**OFFICE OF PHARMACY AFFAIRS**  
**340B Program Registration Form for NEW Family Planning Covered Entities**

Acknowledgement of Covered Entity Participation in Outpatient Discount Drug Pricing under Section 340B of the Public Health Service Act, as amended by Section 602 of the Veterans Health Care Act of 1992

**I. Covered Entity Name:** \_\_\_\_\_  
Street Address: \_\_\_\_\_  
\_\_\_\_\_  
City, State, ZIP \_\_\_\_\_

**Billing Address (if different):** \_\_\_\_\_  
\_\_\_\_\_  
City, State, ZIP \_\_\_\_\_

**Shipping Address (if different):** \_\_\_\_\_  
\_\_\_\_\_  
City, State, ZIP \_\_\_\_\_

**Entity Type:** \_\_\_\_\_ **FP ONLY Grant ID if known or applicable:** \_\_\_\_\_

**II. Medicaid Billing Information** - You **must** answer the following question regarding Medicaid billing.

Do you intend to bill Medicaid for drugs purchased at 340B Drug Prices?    **Yes**            **No**  
If "Yes," your Pharmacy Medicaid Provider Number is required: \_\_\_\_\_

**III. Signed Agreement:**

The covered entity listed above will participate in the 340B Drug Pricing Program. The undersigned represents and confirms that he/she is fully authorized to bind the covered entity and certifies that the contents of any statement made or reflected in this document are truthful and accurate. The covered entity will comply with all of the requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines, including, but not limited to, the prohibitions on duplicate discounts/rebates, and drug diversion.

Grantee Representative Name: \_\_\_\_\_ Title \_\_\_\_\_

Grantee Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Grantee Representative Telephone: \_\_\_\_\_ Ext. \_\_\_\_\_

Grantee Representative Email: \_\_\_\_\_

Entity Contact Name: \_\_\_\_\_ Title \_\_\_\_\_

Entity Contact Telephone: \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: \_\_\_\_\_

Entity Contact Email: \_\_\_\_\_