Reset Form

APPLICATION FOR REGISTRATION AS A NON-RESIDENT PHARMACY IN THE STATE OF INDIANA

State Form 50248 (R13 / 8-23)

INDIANA BOARD OF PHARMACY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 1-27-1.*
2. *All fees are non-refundable and non-transferable.*
3. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

FOR OFFICE USE ONLY		
Application fee	Date fee paid (*month, day, year*)	Receipt number
Date of issuance (*month, day, year*)	Registration number	Case manager

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Type of application *(Please check appropriate box.)*:

☐ New facility ☐ Change of ownership *(provide current Indiana license number)* ☐ Change of location *(provide current Indiana license number)*

Name of pharmacy		Current Indiana license number	
Address of pharmacy (*number and street)*	City	State	ZIP code
Toll-free telephone number (*accessible by Indiana patients*) ( )		Local telephone number ( )	
Name of pharmacist	State	License number	DEA number
E-mail address		Web site address	
If change of ownership, previous name			
If change of location, previous address (*number and street*)	City	State	ZIP code
NCPDP number *(If you currently do not have a NCPDP number, you will need to provide that immediately upon receipt.)*			
Approximate percentage of total prescription volume received or solicited online	Approximate number of Indiana residents to be served	Verified Internet Pharmacy Practice Site (VIPPS) accredited? ☐ Yes ☐ No	
The days of the week and hours that a pharmacist is available to speak to Indiana patients via toll free line (*IC 25-26-17-4 requires at least forty (40) hours and six (6) days a week; if on-call to meet this requirement, **please explain on-call procedure.***)			
When a pharmacist is answering questions from Indiana patients via the toll-free line, does the pharmacist have immediate access to the records and the drug profile of the patient? ☐ Yes ☐ No	If no, please explain.		
Does the pharmacy engage in remote practice? ☐ Yes ☐ No			

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court, has your facility or any of your pharmacists or technicians been convicted of, or pled guilty to, a violation of a federal or state law or are criminal charges pending?	☐ Yes ☐ No
2. Have any of your pharmacist or pharmacy technician licenses been disciplined or are formal charges pending?	☐ Yes ☐ No
3. Has your facility's license(s) been disciplined or are formal charges pending in your state of domicile or any other state in which the facility is licensed?	☐ Yes ☐ No
4. Has your facility been denied a license or registration in any state?	☐ Yes ☐ No
5. Have you had any action, discipline, or revocation on any federal registration you hold or have held?	☐ Yes ☐ No

DELIVERY SERVICES

DELIVERY SERVICE(S) UTILIZED	PERCENTAGE OF TIME UTILIZED

Are there any special packaging or shipping procedures used to assure proper shipping conditions for the medications being shipped to Indiana residents? *Please explain.*

When medications are delivered to Indiana residents, are there any special delivery policies in place? (*Check all that apply.*)

- ☐ Medications must be signed for by
- ☐ Medications may be left with a non-adult person at the household.
- ☐ Medications may be left at the house when no one is at home.
- ☐ Medications do not have to be signed for.
- ☐ Other. *Please explain your policy*: _____

COMPOUNDING

Please provide a copy of the last board inspection report by your home state board of pharmacy.

If the pharmacy engages in compounding, please provide evidence of USP 795/797 compliance, including but not limited to: all compounding-related policies and procedures, evidence of system certification appropriate to the level of compounding, etc.

1. Does your facility engage or plan to engage in sterile compounding? ☐ Yes ☐ No
2. Does your facility engage or plan to engage in non-sterile compounding? ☐ Yes ☐ No
3. Number of sterile and non-sterile compounded prescriptions sent into Indiana every month: _____
4. Number of compounded medications sent into Indiana for practitioner office use: _____

APPLICATION AFFIRMATION

I hereby swear or affirm under penalties or perjury that the statements made in this application are true, complete, and correct.

Signature of pharmacist	Date (*month, day, year*)
Signature of owner / officer	Date (*month, day, year*)

Printed name of owner / officer	Title

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, or the Indiana Board of Pharmacy, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Indiana Board of Pharmacy, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of owner / officer	Date signed (*month, day, year*)