



STATE OF ALASKA
Department of Commerce, Community and Economic Development
Division of Corporations, Business and Professional Licensing
BOARD OF PHARMACY
Physical Address: 333 Willoughby Avenue, 9th Floor, Juneau, Alaska 99801
Mailing Address: P.O. Box 110806, Juneau, Alaska 99811-0806
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PROCEDURE TO OBTAIN AN OUT-OF-STATE PHARMACY REGISTRATION

In accordance with AS 08.80.158, a pharmacy located outside of the state that ships, mails, or delivers prescription drugs to consumers in the state shall register with the board.

NOTE: Please read the application, statutes, regulations, and all instructions carefully. It is your responsibility to be aware of licensing requirements and provide all necessary documentation. The board will not issue a registration until your application is complete.

PUBLIC INFORMATION

All information supplied with this application is available to the public unless required to be kept confidential by state or federal law. Information about licensees, including mailing addresses, is available from the division's website at www.commerce.state.ak.us/occ under "License Search."

APPLICATION FOR REGISTRATION

The following must be on file before the board may review the application for approval:

1. Completed notarized application.
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."

\$ 50.00	Nonrefundable application fee
<u>\$600.00</u>	License fee
\$650.00	Total required
3. Names of all owners/principal corporate officers.
4. Name, address and license number of the pharmacist-in-charge and a list of all pharmacists working in the facility.
5. Toll-free telephone number accessible by patients in the State of Alaska.
6. Federal employer identification number.
7. Certified true copy of the valid facility license from the jurisdiction where the facility is located. (**NOTE:** To obtain a "certified true copy," you must present the notary with the original document along with the photocopy. You must write, "*I certify this is a true copy of the original document*" and sign your name. The notary will compare the original document with the copy and then notarize your signature.)
8. Copy of the most recent inspection report from the jurisdiction where the facility is located. If it is older than two years, complete the self-inspection report located on the website at <http://www.commerce.state.ak.us/occ/ppha.htm>

APPLICATION FOR CHANGE OF OWNERSHIP

In accordance with 12 AAC 52.040, when ownership of a pharmacy changes, a new license is required. The existing license must be returned and a new application, along with the appropriate fees and supporting documentation, must be submitted. The following must be on file before the board may review the application for approval:

1. Completed application and supporting documentation (see 1 through 8 above).
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."

\$ 50.00	Nonrefundable application fee
<u>\$600.00</u>	License fee
\$650.00	Total required

APPLICATION FOR CHANGE OF NAME OR LOCATION

In accordance with 12 AAC 52.030, when the name or location of a pharmacy changes, a new license is required. The existing license must be returned and a new application, along with the appropriate fees and supporting documentation, must be submitted. The following must be on file before the board may review the application for approval:

1. Completed application and supporting documentation (see 1 through 8 above).
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."

\$ 50.00	Nonrefundable application fee
<u>\$ 5.00</u>	Duplicate License fee
\$ 55.00	Total required

ALASKA STATUTES

Sec. 08.80.158. REGISTRATION OF PHARMACIES LOCATED OUTSIDE OF THE STATE. (a) A pharmacy located outside of the state that regularly ships, mails, or delivers prescription drugs to consumers in the state shall register with the board.

(b) A pharmacy registering with the board under (a) of this section shall furnish to the board annually

(1) the location, names, and titles of all principal corporate officers and of all pharmacists who are dispensing prescription drugs to residents of the state;

(2) a copy of a current valid license, permit, or registration to conduct operations in the jurisdiction in which it is located, and a copy of the most recent report resulting from an inspection of the pharmacy by the regulatory or licensing agency of the jurisdiction in which the pharmacy is located.

(3) a sworn statement indicating that the pharmacy complies with all lawful directions and requests for information from the regulatory or licensing authority of the jurisdiction in which the pharmacy is license; and

(4) proof satisfactory to the board that the pharmacy maintains its records of prescription drugs dispensed to persons in the state so that the records are readily retrievable from the records of other prescription drugs dispensed by the pharmacy.

(c) A pharmacy subject to this section shall, during its regular hours of operations, provide a toll-free telephone service to facilitate communication between persons in the state and a pharmacist at the pharmacy who has access to records concerning the dispensing of prescription drugs to persons in the state. The toll-free number and the hours that the service is available shall be disclosed on a label affixed to each container of drugs dispensed to persons in the state. The telephone service shall be available at least 40 hours a week and at least six days a week.

(d) The board may, after a hearing, deny, revoke, or suspend the registration of a pharmacy located outside of the state and subject to this section if the pharmacy fails to comply with the requirements of this section, AS 17.20.080–AS 17.20.135, or AS17.30.020– 17.30.080, or if the license, permit, or registration of the pharmacy is denied, revoked, or suspended by the licensing or regulatory agency of the jurisdiction in which the pharmacy is located.

(e) A pharmacy located outside of the state that is subject to this section but is not registered with the board under this section may not ship, mail, or deliver prescription drugs into the state and may not advertise its services in the state.

(f) A pharmacy subject to this section shall appoint a registered agent in the state who is empowered to accept, on behalf of the pharmacy, process, notice, and demand required or permitted by law to be served upon the pharmacy. If the pharmacy fails to appoint an agent under this subsection, if the registered agent cannot with reasonable diligence be found at the registered office, or if the registration of the pharmacy is suspended or revoked, the commission of commerce and economic development is an agent upon whom process, notice, or demand may be served. Service is made upon the commissioner in the same manner provided for corporations under AS 10.06.175(b), except that for the purposes of AS10.06.175(b)(2)(A), the address shall be the last registered address of the pharmacy as shown by the records of the board.

(g) The board shall by regulation define “regularly” for this section.

PROFESSIONAL REGULATIONS

12 AAC 52.130. REVIEW OF APPLICATIONS FOR REGISTRATION OF PHARMACIES LOCATED OUTSIDE OF THE STATE.

(a) An applicant who meets the requirements on the checklist set out in (b) of this section has demonstrated the necessary qualifications for an out-of-state pharmacy registration. An applicant who does not meet the requirements on the checklist or whose application documents do not clearly show that the applicant is qualified to receive an out-of-state pharmacy registration will not be issued a registration unless the board further reviews the application and determines that the applicant meets the qualifications in AS 08.80 and this chapter for that registration.

(b) The following checklist is established by the board for review by staff of an application for an out-of-state pharmacy registration. An out-of-state pharmacy registration will be issued to an applicant who

(1) applies on an application provided by the department that includes

(A) the company name and owner name;

(B) the pharmacy name;

(C) the location of the facility;

(D) a mailing address and telephone number;

(E) a toll free number accessible by patients in this state;

(F) the federal employer identification number;

(G) the names of all partners or corporate officers;

(H) the name, address, and telephone number for pharmacist-in-charge;

(I) the names of all pharmacists working in the facility;

(J) completion of the professional fitness section of the application; and

(K) the name of the appointed registered agent;

(2) pays the application fee and the out-of-state pharmacy registration fee established in 12 AAC 02.310;

(3) submits a certified true copy of a current, valid facility license or registration from the jurisdiction where the pharmacy is located; and

(4) submits an inspection report or self-inspection report completed within the last two years.

(c) A pharmacy located outside of the state that ships, mails, or delivers prescription drugs more than twice during a 12-month period to individual patients in the state shall register with the board.

12 AAC 52.030. CHANGE OF PHARMACY LOCATION OR NAME. (a) The pharmacist-in-charge of a pharmacy that has changed its name or physical address shall apply for a new and separate pharmacy license. The applicant shall

- (1) submit a new, completed application for a pharmacy license; and
- (2) pay the duplicate license fee required in 12 AAC 02.105;
- (3) *repealed 1/17/2007.*

(b) Within 14 days after commencement of business under the new license, the pharmacist-in-charge of a pharmacy that has changed its physical address shall complete a self-inspection questionnaire on a form provided by the department.

12 AAC 52.040. CHANGE OF PHARMACY OWNERSHIP. (a) *Repealed 1/17/2007.*

(b) A new owner of a pharmacy shall apply for a new and separate facility license in accordance with 12 AAC 52.020.

12 AAC 52.050. CLOSED PHARMACIES. (a) When a pharmacy ceases operations, the pharmacist-in-charge of that pharmacy shall

(1) submit to the board a written notice of the cessation of pharmacy operations; the written notice must be submitted within 10 days after the cessation of operations and include

(A) the date the pharmacy ceased operations;

(B) a statement signed by the pharmacist-in-charge attesting that an inventory of all controlled substances on hand has been conducted; and

(C) a statement signed by the pharmacist-in-charge attesting to the manner of disposition for all prescription drugs possessed by the pharmacy;

(2) arrange for the transfer of prescription drug orders or computer prescription records to another pharmacy to facilitate continuous patient care; and

(3) provide for the maintenance and availability of prescription drug orders or hard copies of computer prescription records in accordance with 12 AAC 52.450(a) that are not transferred to another pharmacy;

(4) *repealed 1/17/2007.*

(b) In the absence of a pharmacist-in-charge, the owner of the pharmacy shall meet all requirements of this section.



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OUT-OF-STATE PHARMACY REGISTRATION APPLICATION

- Application options: New application (\$ 650.00), Changes (Change ownership \$ 650.00, Name change only \$ 55.00, Location change \$ 55.00) with existing license number fields.

THIS APPLICATION MUST BE COMPLETED IN FULL. If any section does not apply, please write N/A in the space provided. TYPE OR PRINT IN INK ALL INFORMATION. A personal check, certified check, or money order payable to the "State of Alaska" MUST accompany this application.

Company/Owner Name: _____

Pharmacy Name: _____

Street Address: _____

Zip Code: _____

Mailing Address: _____

Zip Code: _____

Telephone Number: _____ Toll-Free Telephone Number: _____

Federal Employer Identification Number: _____

Name and Address of Alaska Registered Agent (if not applicable, please state "none"): _____

Ownership of Pharmacy:

NOTE: Licenses are nontransferable and any change of name, location, ownership requires application for a new license.

Table with 2 columns: Ownership type (Sole Proprietorship, Partnership, Corporation) and Title. Includes rows for Name of Owners/Partners/Officers.

Personnel:

Name of Pharmacist-in-Charge: _____ License Number: _____

Address of Pharmacist-in-Charge: _____ Telephone: _____

Zip Code: _____

List all licensed pharmacists employed:

Table with 2 columns: Name, License Number. Includes multiple rows for listing pharmacists.

Type of facility – Check all that apply

Community Mail Order Compounding Internet Other _____

Professional Fitness:

The following questions must be answered. If any of the following answers are “yes,” please explain in detail, in affidavit form, on a separate sheet, and provide any supporting documents.

1. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee violated a federal, state, or local law relating to the practice of pharmacy, drug samples, wholesale or retail drug or device distribution, or distribution of controlled substances? . Yes No
2. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee had a felony conviction under federal, state, or local law? Yes No
3. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee furnished false or fraudulent material in an application made in connection with drug or device manufacturing or distribution?..... Yes No
4. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee had a suspension or revocation by federal, state, or local government of a license currently or previously held for the manufacture or distribution of drugs or devices, including controlled substances? Yes No
5. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee obtained remuneration by fraud, misrepresentation, or deception? Yes No
6. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee had dealings with drugs or devices that are known or should have been known to be stolen drugs or devices?..... Yes No

By signature below, I attest to the following (refer to AS 08.80.158):

That the pharmacy complies with all lawful directions and requests for information from the regulatory or licensing authority of the jurisdiction in which the pharmacy is licensed.

That the pharmacy maintains its records of prescription drugs dispensed to persons in Alaska so that the records are readily retrievable from the records of other prescription drugs dispensed by the pharmacy.

That during regular hours of operation, a toll-free telephone service is provided to facilitate communication between persons in Alaska and a pharmacist at the pharmacy who has access to records concerning the dispensing of prescription drugs to persons in Alaska. The toll-free number and the hours that the service is available shall be disclosed on a label affixed to each container of drugs dispensed to persons in Alaska. The telephone service shall be available at least 40 hours a week and at least six days a week.

I further attest that the information contained in this application is true and correct. I understand that information supplied with this application is considered public, unless required to be kept confidential pursuant to state or federal law.

Signature of Owner or Officer

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20_____.

NOTARY SEAL

Notary Public

My Commission Expires: _____



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Authorization for Release of Records

To Whom It May Concern:

I, _____

as owner or officer of _____
(name of pharmacy)

located at _____

authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine records pertaining to litigation, suits, judgments and/or settlements, and any law enforcement records pertaining to the pharmacy and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to the pharmacy to the Alaska Division of Corporations, Business and Professional Licensing and its investigators.

I authorize the Division to discuss the records with persons or organizations which are considered appropriate by the Division in connection with an official investigation, and to provide copies of the records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis or treatment received by an owner or officer as it pertains the practice of pharmacy and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis, or treatment.

I request that upon presentation of this release, or a Certified True Copy, that you provide copies of the records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with our application for licensure as a pharmacy and expires one (1) year from the date of my signature below.

I hereby release you, your organization, the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing and its investigators, and all others directly or indirectly involved in this matter from any liability or damage which may result from furnishing the information requested.

SIGN HERE



Signature of Owner or Officer

Date

NOTE: A photocopy reproduction of this request shall be, for all intents and purposes, as valid as the original. You may retain this form for your files.



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 Fax: (907) 465-2974

OFFICE USE ONLY

CREDIT CARD PAYMENT

For security purposes, please **do not email** credit card information. Fax or mail this form to the Division. Completion of this form is not proof of payment until the division processes the information contained herein. If any information on this form is illegible, the form will be rejected. Please print.

Name of Applicant or Licensee: _____
Corporate or Individual (first, middle, last)

License Number (if applicable): _____

Type of License: _____

I wish to make payment by credit card for the following:
(check all that apply)

- | | Amount |
|---|--------|
| <input type="checkbox"/> Application fee | _____ |
| <input type="checkbox"/> License (or renewal) fee | _____ |
| <input type="checkbox"/> Fine | _____ |
| <input type="checkbox"/> Other (specify): _____ | _____ |

Total: _____

Print Name on Credit Card: _____

Complete Mailing Address: _____

Telephone Number: _____

Signature of Credit Card Holder: _____

Credit Card Type (check one): VISA MASTERCARD

Card Number: _____

Please provide the 3-digit security code number from the back of the card: _____

Expiration Date: _____