NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln, NE 68509-4986

ACCOUNTING
Business Unit 25550346

APPLICATION FOR LICENSE TO OPERATE A REMOTE DISPENSING PHARMACY

Application Fee: $625.00 (Make check payable to DHHS Licensure Unit)

SECTION A—LICENSE INFORMATION			
Name of Supervising Pharmacy:			
Physical Address:	Street/PO/Route:		
	City:	State:	Zip:
Telephone Number:		Fax Number:	
E-mail Address:			
Anticipated Opening Date for the Remote Dispensing Pharmacy:			
Please supply a contact person if we have questions:	Name:		
	Phone:	E-mail:	
Name & Address for Remote Dispensing Pharmacy:	Name of Remote Dispensing Pharmacy:		
	Street/PO/Route:		
	City:	State:	Zip:
Days/Hours Remote Dispensing Pharmacy Open for Business:			
PIC Information:	Name:	License #:	Expiration date:

Is the remote dispensing pharmacy located at least 10 driving distance miles or more from the nearest pharmacy?

☐ YES ☐ NO

Please provide documentation demonstrating identity & location(s) of the nearest pharmacy(s).

SECTION B — CONTROLLED SUBSTANCES REGISTRATION
Are controlled substances to be dispensed by the remote dispensing pharmacy? *If so, a Federal Controlled Substances Registration is required. Please include a copy of your DEA registration.* ☐ YES ☐ NO Registration #
You may apply for a federal controlled substances registration on-line at www.deadiversion.usdoj.gov

SECTION C — STAFFING AND STANDARDS FOR OPERATION FOR A REMOTE DISPENSING PHARMACY		
Does the remote dispensing pharmacy employ one or more certified pharmacy technicians to dispense prescription drugs?		
Name of the Certified Pharmacy Technician: (Please use additional sheet for any additional certified pharmacy technicians will be working at the remote dispensing pharmacy site.)	Nebraska Pharmacy Technician Registration #:	Certification issued by: _____ Certification #: Expiration date of certification: _____
Is an operable real-time audiovisual communication system in place at both the remote dispensing and supervising pharmacy location in order to ensure medication is dispenses under the supervision by a Nebraska licensed pharmacist located at the supervising pharmacy in Nebraska? ☐ YES ☐ NO Please attach a narrative description (photos of system can be included with the narrative) of how it will be used by both the remote dispensing pharmacy staff and the supervising pharmacy staff.		
Are there safeguards in place to assure that no remote dispensing can occur if the real-time audiovisual communication system between the remote dispensing pharmacy and supervising pharmacy is not working, until the real-time audiovisual communication system is restored and working properly? ☐ YES ☐ NO Please describe:		
Please type or print clearly a **detailed** description of how the remote dispensing pharmacy will meet the following requirements in compliance with 175 NAC 8, Sections 8-006 and 8-007. If you need additional room, you may attach a separate sheet)		
1.	How will the prescription inventory and prescription records of the remote dispensing pharmacy be secured when there is no pharmacist on the premises? (see 8-006.02C)	

2.	How will the supervising pharmacy ensure that drugs, devices, and biologicals are kept at the proper temperature within the remote dispensing pharmacy? (see 8-006.02A)
3.	How will the supervising pharmacy ensure that none of its saleable inventory at the remote dispensing pharmacy contains any drug, device, or biological which is misbranded or adulterated? (see 8-006.02D)
4.	What services will the remote pharmacy be providing? (Examples of services which may be provided by a pharmacy include, but are not limited to: ambulatory dispensing, automated dispensing)
5.	What facilities, utilities, and equipment will be provided at the remote dispensing pharmacy? (see 8-007 and 8-006.02) (Facilities include such items as counters, drawers, shelves, etc. Utilities include such items as lights, heat/air conditioning, electricity, hot/cold running water. Equipment includes such items as real-time audiovisual equipment, record keeping system, etc.)

SECTION D — AFFIDAVIT

I hereby state that I am the person making application, I am of good character, and the statements on this application are true and complete.

If the applicant is a sole proprietorship for the purpose of complying with Neb. Rev. Stat. §4-108 through 4-114, the applicant must attest as
follows (place a check mark in the appropriate box below):

- ☐ I am a citizen of the United States; or
- ☐ I am a qualified alien under the Federal Immigration and Nationality Act. I have provided my immigration status and alien number and agree to provide a copy of my United States Citizenship and Immigration Services (USCIS) documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

The application must be signed and dated by (place a check mark in the appropriate box below):

- ☐ The owner or owners if the applicant is a sole proprietorship, a partnership, or a limited liability company that has only one member;
- ☐ Two of its members if the applicant is a limited liability company that has more than one member;
- ☐ Two of its officers if the applicant is a corporation;
- ☐ The head of the governmental unit having jurisdiction over the business if the applicant is a governmental unit; or
- ☐ If the applicant is not an entity described above, the owner or owners or, if there is no owner, the chief executive officer or comparable official.

_____	_____	_____
(Printed Name & Title of Applicant)	(Signature & Title of Applicant)	(Date)

_____	_____	_____
(Printed Name & Title of Applicant)	(Signature & Title of Applicant)	(Date)