PENNSYLVANIA STATE BOARD OF PHARMACY

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PO Box 2649
Harrisburg, PA 17105-2649

Courier Address: (UPS, FED-EX, etc.)
PA Dept of State, Bureau of Professional and Occupational Affairs
Attn: State Board of Pharmacy
2 Technology Park
Harrisburg, PA 17110-2919

SATELLITE PHARMACY APPLICATION # 854 110 (Rev 4/15)

Check one:
( ) New satellite pharmacy...$125.00 fee
( ) Change in location of an existing satellite pharmacy…$125.00 fee
( ) Remodel of an existing satellite pharmacy…$125.00 fee

Make fee payable to the "Commonwealth of PA." Fees are not refundable. Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

This application must be reviewed for acceptability by the Board of Pharmacy's Floor Plan Review Committee. Construction may not begin on the satellite pharmacy until the application is approved. Notice of approval will be mailed to the contact person. If the Board objects to the application, notice of disapproval will be sent to the contact person and construction may not begin until the discrepancy is resolved.

Name of hospital pharmacy:____

Pharmacy permit number:____

Address of pharmacy:____
Street

____, PA____________
City Zip Code

Contact person's name:____

Contact person's phone number:____

Contact person's fax number:____

Contact person's e-mail address:____

Expected date satellite pharmacy will be ready for inspection:______________________
(Month/Day/Year)

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

____ ____________
Signature of the Registered Pharmacist Manager Date

____
Printed Name of Registered Pharmacist Manager

License Number:__RP-___________________________________

AND ____ ____________
Signature of the Owner's Authorized Representative Date

Title:____

Printed Name:____

A satellite pharmacy that fails the inspection will be required to pay $115.00 for re-inspection. It will be the responsibility of the pharmacy owner to notify the Board office in writing when the satellite pharmacy is ready for re-inspection.

Correcting any deficiency or violation noted on the inspection report will be the responsibility of the owner. The Board will grant a period of not more than thirty days to correct the deficiency. Failure to do so will be just cause for the Board to take other appropriate action.

It is your responsibility to maintain a copy of this and all documents submitted to the Board or received from the Board for your future reference.

The information contained in this application is valid for only one year. If the application is pending and the pharmacy has not passed its required inspection within one year of the original date of submission of this application, the Board will request submission of a new application along with the required application fee.

A satellite pharmacy is defined as a pharmacy in an institution which provides specialized services for the patients of the institution and which is dependent upon the centrally located pharmacy for administrative control, staffing, and drug procurement. The term does not include a pharmacy serving the public on the premises of the institution nor does it include a pharmacy located off premises from the centrally located pharmacy of the institution regardless of whether the pharmacy is owned by the same person or entity which owns the institution.

What specialized services for the patients of the institution will the satellite pharmacy provide?

____

Is the satellite pharmacy in the same building as the central hospital pharmacy?
Yes (   )   No (   )
If your response is "No", please provide an explanation:___________________________

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Please note the exact location of the central hospital pharmacy:_____________________

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Please note the exact location of the proposed satellite pharmacy:___________________

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Please note the distance between the central hospital pharmacy and satellite pharmacy:__

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Please identify the total number of pharmacists that will work at this satellite pharmacy on a daily basis:______________________

Please draw a skeleton sketch showing the floor plan and dimensions of the proposed satellite pharmacy. Blue prints will not be accepted in lieu of this sketch. Also, please indicate the placement of any relevant items such as counters, a sink, an IV hood or a refrigerator <u>if</u> these items will be present. Additional 8 ½" x 11" sheets of paper may be attached if more space is needed.

*****FOR <u>REMODELS</u> OF EXISTING SATELLITE PHARMACIES ONLY*****

1. Please also submit floor plans for the **<u>existing</u>** satellite pharmacy (i.e. before construction) on a separate 8 1/2" x 11" sheet of paper.

2. List the precautions taken to protect the health and safety of the professionals, employees, and the public during the continuing operation of the satellite pharmacy while the satellite pharmacy is being remodeled. Please include information on procedures that will be put into place to protect the drugs and devices from dust and dirt, to prevent unauthorized access to prescription drugs and devices, etc. Please also indicate if a Pennsylvania-licensed pharmacist will be present during construction.

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Helpful Information

Before submitting your application, please refer to the following helpful hints. Keep in mind that original application pages, not photocopies nor faxed copies, must be submitted along with the application fee.

Page One:

1. Have you provided the pharmacy's registered name, permit number and address? This information is printed on the centrally located pharmacy's current permit.
2. Have you provided complete information for the contact person?
3. Have you provided the inspection ready date in month/day/year format?

Page Two:

1. Has the registered pharmacist manager signed, dated, printed his name and listed his license number?
2. Has the pharmacy owner's authorized representative signed, dated, listed his/her title and printed his/her name?
3. Are you submitting the original application page two?

Page Three:

1. Have you answered all of the questions?
2. Have you provided sufficient information in order for a determination to be made regarding whether this pharmacy meets the definition of a "Satellite pharmacy"? If necessary, additional information may be provided on 8 ½" x 11" paper. Please keep in mind that a satellite pharmacy is **not** permitted to fill prescriptions that will be sent home with a patient for future use.

Page Four:

1. Are the floor plans on 8 ½" x 11" paper? The Board is unable to accept larger floor plans as they cannot be microfilmed/scanned.
2. Floor plans:
   If present, are the sink, refrigerator, IV hoods, and work counter identified?
   Are all walls shown as well as placement of the doors?
   Are the different rooms identified?
   Are the fixtures shown in each room?
3. If the centrally located pharmacy and the satellite pharmacy are located some distance apart, please consider whether a map showing both locations would be helpful to the Floor Plan Review Committee when evaluating the application.
4. If it is necessary to transport drugs a significant distance between the centrally located pharmacy and the satellite pharmacy, please consider whether it would be helpful to describe how drug stock will be safely transported between the centrally located pharmacy and the satellite pharmacy.

Page Five:

1. **If** this application is for a remodel of an existing satellite pharmacy, have you submitted floor plans for the existing satellite pharmacy (i.e. before construction) on a separate 8 ½" x 11" sheet of paper?
2. **If** this application is for a remodel of an existing satellite pharmacy, have you provided all of the information that was requested under item two on this page?