

PENNSYLVANIA STATE BOARD OF PHARMACY
PO Box 2649
Harrisburg, PA 17105-2649
717-783-7156 st-pharmacy@pa.gov

**CANCER DRUG REPOSITORY PROGRAM
DONATION, DISPENSING, TRANSFER AND DESTRUCTION RECORD #854 123**

Completion of this form meets the requirements under the Cancer Drug Repository Program Act, 62 P.S. §§2921-2927 for donating drugs, for distribution of drugs to a participating repository and for destruction of drugs under the Cancer Drug Repository Program. This form must be maintained for at least two years.

DONATION INFORMATION

Name – Donor (print or type)

Date Donated

Name – Pharmacy or Medical Facility Receiving Donation

Medication Name

Medication Strength

Expiration Date

Lot Number

Quantity Donated

Name of Pharmacy That Originally Dispensed the Cancer Drug

Name of the Person to Whom the Cancer Drug Was Originally Prescribed

I certify that the above-named drug was stored as recommended by the manufacturer and that the drug has never been opened, used, tampered with, adulterated, or misbranded.

SIGNATURE – Donor or Designee

Date Signed

Donor or Designee's Printed Name

Name of Pharmacist Accepting Donation

Pharmacist License No.
RP-

DISPENSING RECORD

Name of the Person to Whom the Drug was Dispensed

Date of Dispensing

Name of Prescribing Practitioner

Was a handling fee charged? ___ No ___ Yes If "Yes", insert the handling fee: \$_____.

DISTRIBUTION OF DONATED DRUG TO A PARTICIPATING REPOSITORY

A PHOTOCOPY of the original donation form must accompany this form for all distributions between participating repositories.

Name – Pharmacy or Medical Facility Receiving Drug

Date Distributed

Quantity of Medication Distributed

Was a handling fee charged? No Yes If "Yes", insert the handling fee: \$_____.

DESTRUCTION OR DISPOSAL INFORMATION

Medication Name, Strength and Quantity

Source of Medication

Name of Person or Firm Destroying or Disposing of Drug

Date of Destruction/Disposal