COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF PHARMACY
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Harrisburg, PA 17105-2649
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CANCER DRUG REPOSITORY PROGRAM
RECIPIENT RECORD AND INFORMED CONSENT #854 118

Completion of this form meets the requirements under the Cancer Drug Repository Program Act, 62 P.S. §§2921-2927 for dispensing or administering medications to recipients who meet the eligibility requirements of the Cancer Drug Repository Program. This form must be maintained by the dispensing pharmacy for at least two years from the date that the patient signs it.

PHARMACY INFORMATION

Registered Pharmacy Name (print or type)	Cancer Drug Repository Approval Number

RECIPIENT INFORMATION

Recipient Name (print or type)	Date Received

Medication

Medication Strength	Expiration Date	Lot Number	Quantity Received

ELIGIBILITY CERTIFICATION: Please initial next to each statement.

_____a. I hereby certify that I am a Pennsylvania resident, residing at the following address:

_____

_____b. I hereby certify that I have been diagnosed with cancer.

_____c. I hereby certify that I do not possess or have limited prescription drug coverage related to the treatment of cancer so that the coverage limits prevent me from obtaining cancer drugs.

_____d. I hereby certify that I do not meet the eligibility requirements under the State Medical Assistance Program that provides prescription drug coverage related to the treatment of cancer.

_____e. I hereby certify that my prior year's family income of _____does not exceed 350% of the prior year's Department of Health and Human Services Federal Poverty Income Guidelines for a family of _____(enter number).

VERIFICATION STATEMENT:

I understand that the above-named medication that I am receiving has been donated, may have been previously dispensed, is unused, and has potentially been stored in a non-controlled environment. I understand that a visual inspection has been conducted by the pharmacist in such a manner as to be able to reasonably determine that the drug has not expired, has not been adulterated or misbranded and is in its original unopened, sealed and tamper-evident packaging. I understand that the dispensing pharmacist, the prescribing or administering practitioner, the cancer drug repository, the Board of Pharmacy, and any other participant of the Cancer Drug Repository Program cannot guarantee the safety of the drug being dispensed or administered and that the pharmacist has determined that the drug appears to be safe to dispense or administer **based on the accuracy of the donor's form submitted with the donated drug** and the visual inspection required to be performed by the pharmacist before dispensing or administering.

SIGNATURE – Recipient	**DATE SIGNED**