



NEW HAMPSHIRE BOARD OF PHARMACY

PRESCRIPTION DRUG / DEVICE MANUFACTURER / WHOLESALER / DISTRIBUTOR / BROKER

APPLICATION INSTRUCTIONS

1. Applicants must review the NH State laws/rules which apply to the license type for which they are applying prior to submitting the application. The applicable laws/rules are included with this application. **Do not submit this cover page or the laws/rules with your application** – these are to be kept by the applicant for future reference.
2. Complete application in its entirety – do not leave sections blank. If a section does not apply, you must write N/A and the reason it is not applicable.
3. Include a check payable to “Treasurer, State of New Hampshire” for the \$500 application fee.
4. Include all required attachments noted on the application form and in the attached rules. Applications without these required attachments cannot be processed.
5. Applications cannot be kept on hold indefinitely while the Board awaits for the applicant to comply with all application requirements. **The entire application process must be completed within 60-days.** If the applicant does not provide all of the information or documentation required to process their application within 60-days of the initial receipt of the application, then the Board is required to close out the application and the application fee is not refundable. The applicant will need to reapply to be considered for licensure if the 60-day period has expired on their initial application submission.
6. The Board only sends electronic licenses by email. The license can only be sent to one email address. Be sure you fill out the correct email address in which you want the license emailed on the application form. The licenses will be as PDF attachments from the following unmonitored email address: nhlicenses@doit.nh.gov Do not reply to this unmonitored email address with questions or issues with the emailed license. Instead email Board licensing staff directly at pharmacy.licensing@oplcnh.gov
7. Please do not call the Board office to check on the status of your submitted application. You can monitor your application status by going to our license verification page at <https://nhlicenses.nh.gov/verification/Search.aspx?facility=> Your application status will change from “Pending” to “Active” once it has completed the application process. Initial applications generally take around 3 weeks for review/processing by Board staff. If it has been over 3 weeks and you have not received your emailed license and the status still shows as “Pending” on the above verification site, please email pharmacy.licensing@oplcnh.gov to request a status update.

- DO NOT SUBMIT THIS INSTRUCTION SHEET WITH APPLICATION -

Make Check Payable To:
Treasurer, State of NH

Application Fee: \$500
Reinstatement is
additional \$25.00

State of New Hampshire
Board of Pharmacy

7 Eagle Square, Suite 300
Concord, NH 03301
Tel (603) 271-2350 Fax (603) 271-2856
www.oplc.nh.gov/pharmacy

**APPLICATION FOR MANUFACTURER, WHOLESALER, BROKER, REPACKER, RELABELER OR DISTRIBUTOR OF PRESCRIPTION DRUGS
OR DEVICES FOR SALE OR DISTRIBUTION IN NEW HAMPSHIRE AT WHOLESALE (NOT TO THE END PATIENT)**

(NOT FOR USE TO APPLY FOR A BULK COMPOUNDING / 503B OUTSOURCING PERMIT)

| | |
|--|---|
| Location Of Facility Where Actual Manufacturing / Distribution Takes Place (If Broker Only, Business Mailing Address): | |
| Company Name: _____ | |
| Street Address: _____ | |
| City / State / Zip: _____ | |
| Parent Company (If none, write 'None'): | State Of Incorporation (If Corp.): |
| Provide the name, title, & business mailing address of the person to whom the permit, future renewal applications, and all Board communications should be directed: | |
| Name: | Title: Tel. #: |
| Mailing Address: | |
| E-Mail Address (<u>Must</u> Be Entered to Receive Your NH License): | |
| Nature of Business: (Check one) - <i>Note: Bulk Non-Sterile & Sterile Compounding / Outsourcing / FDA 503B Facilities <u>Cannot</u> Be Licensed as Manufacturers or Wholesalers in NH:</i> | |
| <input type="checkbox"/> Manufacturer * <i>If checked, is your company currently licensed by the FDA?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Virtual Manufacturer | |
| <input type="checkbox"/> Wholesaler/Distributor <input type="checkbox"/> Broker/Reseller <input type="checkbox"/> Relabeler/Repackager <input type="checkbox"/> Virtual Distributor | |
| <input type="checkbox"/> 3PL (Third Party Logistics) Provider (licensure required only if Rx products are physically warehoused/stored in the 3PL's own warehouse/distribution center prior to shipping) | |
| <input type="checkbox"/> Reverse Distributor <input type="checkbox"/> Other (please describe activity): | |
| DEA Number (If Shipping Controlled Drugs): | Home State Controlled Substance Lic. #, If Applicable: |
| Is the above referenced company (physical location) licensed by the state licensing authority or board of pharmacy in the state of location? | <input type="checkbox"/> Yes <input type="checkbox"/> No * <i>* If 'No', you must attach an explanation.</i> |
| Within the last 3-years, has a registration or licensure granted to the above referenced company by <u>any</u> state or federal agency been suspended, revoked, or otherwise disciplined? | <input type="checkbox"/> Yes * <input type="checkbox"/> No <i>* If "Yes", attach a detailed explanation, along with copy of legal documentation noting discipline.</i> |

APPLICATION CONTINUED ON NEXT PAGE ↴

Name of Owner(s): Indicate Individual, Partners, Etc. (If Corporation, Show Title of Officers). Attach Additional Sheet If Necessary.

| Name | Title | Address |
|------|-------|---------|
|------|-------|---------|

| Name | Title | Address |
|------|-------|---------|
|------|-------|---------|

Which of the following entities do you sell / ship to?

- Retail Pharmacies Hospital Pharmacies Physicians Dentists
 Veterinarians Other Wholesalers Other _____

Categories of product being sold / shipped into New Hampshire at wholesale?

- Controlled Substances Human Prescription Drugs Veterinary Prescription Drugs
 Prescription Devices (At Wholesale) Medical Gases (At Wholesale) Other _____

Attachments & Declaration / Signature By Company Representative:

I affirm that I am the person authorized to sign this application for licensure and affirm that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the registration herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State.

ATTACHMENTS REQUIRED:

(ALL REQUIRED ATTACHMENTS MUST BE SUBMITTED OR YOUR APPLICATION WILL NOT BE PROCESSED)

I confirm that the following attachments have been attached to this renewal form:

- 1. A copy of the facility's current license/registration issued by the Board of Pharmacy or other state regulatory agency where the facility is located (home state);
- 2. A copy of the facility's current Federal DEA Registration Certificate if shipping controlled drugs;
- 3. A copy of the facility's most recent inspection report issued by either the FDA, NABP / VAWD Accreditation, or State Board of Pharmacy where the pharmacy is located (home state).
- 4. Attach 2 photographs of the existing exterior of the facility in which the applicant is located. These photographs shall include any outside signage. Artist sketches or architect plans or drawings are not acceptable.
- 5. Attach at least 4 photographs of the interior of the facility showing legend drug storage areas, refrigeration units and any specially constructed areas for storage of controlled substances.
- 6. In-state applicants must also submit a scaled floor plan of the facility.
- 7. Attach a list of all states (spreadsheet format preferred) where currently licensed, and include license number.
- 8. Check for \$500 payable to "Treasurer, State of New Hampshire".

Signature: _____ Title: _____ Date: _____

INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT REQUIRED ATTACHMENTS CANNOT BE ACCEPTED.

DO NOT LEAVE ANY BLANK SPACES – IF NOT APPLICABLE, WRITE N/A & THE REASON IT DOES NOT APPLY.

ANY SUBSEQUENT CHANGES TO THE INFORMATION ON THIS FORM MUST BE REPORTED TO THE BOARD IN WRITING WITHIN 30 DAYS OF CHANGE.