South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Pharmacy
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11927 • Columbia • SC 29211-1927
Phone: 803-896-4700 • Contact.pharmacy@llr.sc.gov • Fax: 803-896-4596
llr.sc.gov/bop

NON-RESIDENT CENTRAL FILL PHARMACY PERMIT APPLICATION REQUIREMENTS AND INSTRUCTIONS

This permit authorizes facilities outside of this state engaged in the business of central filling prescriptions to engage in the sale, distribution, or dispensing of legend drugs or devices in this State.

The pharmacist-in-charge for the applicant must attend a Virtual Application Review Committee meeting. Applicant will be notified by email of the date and time of the meeting for which its application review hearing is scheduled. All requested information and an emailed confirmation are required prior to the meeting date. Using false, fraudulent, forged statement or document, or committing a fraudulent, deceitful or dishonest act or omitting a material fact in obtaining licensure is grounds for discipline or licensure denial. A South Carolina Non-Resident Central Fill Pharmacy Application has a one-year expiration.

Failure to complete all required fields and/or provide necessary supplemental documentation will delay the application process. If an item is not applicable, please indicate N/A. **In order to avoid delay, please do not provide the items below in a binder, folder or use dividers. Also, provide items in the order as listed below. Please write legibly. Provide single sided documents only. Retain copies of all document submitted.**

Include this checklist with your application (check N/A if not applicable):

Included	N/A	
☐	☐	Check or money order only (no cash) in the amount of $420.00 made payable to SC Board of Pharmacy. (Application fee is non-refundable. A returned check fee of up to $30, or an amount specified by law, may be assessed on all returned funds.)
☐	☐	Copy of resident state pharmacy permit
☐	☐	Copy of recent operational inspection report. Inspection must have been conducted within the last 2 years.
☐	☐	Copy of current DEA registration
☐	☐	Copy of resident state controlled substance registration
☐	☐	Example of a dispensed prescription label that complies with the following: • Name and address or name and pharmacy license number of the pharmacy filling the prescription; • Name and address of the originating pharmacy which receives the filled prescription for delivery to the patient or the patient's agent; • In some manner indicate which pharmacy filled the prescription; and • All other labeling requirements of federal and state law
☐	☐	Letter describing, in detail, the nature of your business
☐	☐	Provide a list of all pharmacy permits/licenses held in other states, to include permit number and expiration date
☐	☐	Photographs o Exterior of pharmacy building to include identifiable parts of adjacent buildings, front and back o Work area o Inventory o All automated dispensing equipment
☐	☐	Include organizational chart from the ultimate parent company down to and including the applicant.
☐	☐	If a change of ownership, include organization charts of before and after the change. Chart must include names of owners with a 10% or greater ownership interest if a non-publicly traded company.

☐ ☐ A central fill policy and procedure manual must be maintained at both the originating and central fill pharmacies and must be available for inspection. The originating and central fill pharmacies are required to maintain only those portions of the policy and procedure manual that relate to that pharmacy's operations. For the central fill pharmacy, submit the following policies and procedures:

- patient notification of central fill processing;
- confidentiality and integrity of patient information procedures;
- drug utilization review;
- record keeping and logs, including a list of the names, addresses, phone numbers, and license or registration numbers of the pharmacies, pharmacists, and pharmacy technicians at the central fill pharmacy and at the originating pharmacy;
- counseling responsibilities;
- procedures for return of prescriptions not delivered to a patient and procedures for invoicing medication transfers;
- policies for operating a continuous quality improvement program for pharmacy services designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems;
- safe delivery of prescriptions to patients;
- processes to ensure stability and potency of medication;
- requirements for storage and shipment of prescription medication;
- procedures for conducting an annual review of written policies and procedures and for documentation of this review; and
- list of originating pharmacies that will outsource prescription drug orders to this central fill pharmacy.

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NON-RESIDENT CENTRAL FILL PHARMACY PERMIT APPLICATION

☐ New Facility

☐ Change to Existing Permit (Permit No.: _____)
- ☐ Change of Name
- ☐ Change of Location (from one city to another)
- ☐ Change of Ownership (include organizational chart before and after change)

FOR BOARD USE ONLY	
Date Paid	
Amount Paid	

FACILITY INFORMATION

FEIN No.: _____ NABP e-profile ID No.: _____

Legal Name of Pharmacy: _____

DBA Name: _____

Street address of physical location of pharmacy: _____

City: _____ State: _____ Zip: _____

Resident State Permit/Licensure No.: _____

Is application based on a change in ownership? ☐ Yes ☐ No

If Yes: _____ SC Permit No.: _____
Previous Owners/Name of Pharmacy

Phone No.: _____ Toll-Free No.: _____

Email (for all correspondence): _____

Mailing Address where all correspondence regarding licensure will be sent if other than facility physical address above:

Contact Person: _____ Facility Name: _____

Street: _____ City: _____ State: ___ Zip:_____

1. Will the facility fill prescriptions provided directly by a patient or an individual practitioner? ☐ Yes ☐ No

   If Yes, the facility will also need a Pharmacy Permit.

2. Will the facility mail or otherwise deliver a prescription directly to a patient or individual practitioner? ☐ Yes ☐ No

   If Yes, the facility will also need a regular pharmacy permit.

   Website link for Pharmacy Permit Application:
   https://llr.sc.gov/bop/PFORMS/Non-Resident_Pharmacy_Permit_App.pdf

CONTROLLED SUBSTANCES

Non-resident central fill permitted by the SC Board of Pharmacy that dispense controlled substances are required to obtain a South Carolina Controlled Substances Registration from the SCDHEC-Bureau of Drug Control.

Access the application via the website at
www.dhec.sc.gov/Health/FHPF/DrugControlRegisterVerify/NewRegistrations/.

Does your pharmacy dispense controlled substances? ☐ Yes ☐ No

COMPOUNDING

Does your pharmacy do compounding? ☐ Yes ☐ No
Sterile compounding? ☐ Yes ☐ No
Non-sterile compounding? ☐ Yes ☐ No

If Yes, you may be required to provide additional documentation.

OWNERSHIP

☐ **Sole Proprietorship** Name of Business Entity: _____

Name	City, State	Birth Year

☐ **General Partnership** ☐ **LLP** Name of Partnership/LLP: _____

Partner Name	City, State	Birth Year	% of Ownership

☐ **Corporation** ☐ **LLC** Legal Name of Corporation/LLC: _____

Is this company publicly traded? ☐ Yes ☐ No

Name of Parent Company: _____ State of Incorporation: _____

Name of Individual Owners and Principal Officers	Title	City, State	Birth Year	% of Ownership
1.				
2.				
3.				

Pursuant to S.C. Code Ann. §40-43-83 (E) The board may enter into agreements with other states or with third parties for the purpose of exchanging information concerning the permitting and inspection of entities located in this jurisdiction and those located outside this State.

DISCIPLINARY HISTORY
If you answer "Yes" to any part of this section, provide a detailed explanation on a separate sheet and attach copies of applicable court documentation. Include the city and state where the offense(s) occurred.

TO THE BEST OF YOUR KNOWLEDGE HAS THE APPLICANT, the entity, undersigned permit holder, any person or entity identified in the ownership/management section above, or any entity under common control with the applicant ever:

1. Has any license or permit held by the applicant, permit holder, or by any owner or corporate officer, ever been disciplined, denied, refused, voluntarily surrendered, agreed to permanently cease operations or revoked for violations of any federal or state pharmacy laws or drug laws regardless of state? ☐ Yes ☐ No

   Is there any pending disciplinary action? ☐ Yes ☐ No

2. Been convicted, fined or entered in a plea of guilty or nolo contendere in any criminal prosecution, felony or misdemeanor in South Carolina or any other state, or in a United States court for:

   a. any offense relating to drugs, narcotics, controlled substances or alcohol, whether or not a sentence was imposed? ☐ Yes ☐ No

   b. any offense involving the practice of pharmacy, or relating to acts committed within a pharmacy or drug/device manufacturer setting or incident to pharmacy practice, whether or not a sentence was imposed? ☐ Yes ☐ No

   c. any offense involving fraud or, dishonesty whether or not a sentence was imposed? ☐ Yes ☐ No

3. Had an application for a drug/device distributor permit, pharmacy, or pharmacist license, permit or certificate or a technician license or registration, denied or refused in South Carolina or any other state or country? ☐ Yes ☐ No

4. Had disciplinary action taken against you, or a pharmacy or drug manufacturer facility You owned, or a pharmacy or drug/device distributor facility where you were employed, By the Board of Pharmacy (or its equivalent) in South Carolina or any other state or country? ☐ Yes ☐ No

5. Operated, or allowed the facility to operate without a valid permit? ☐ Yes ☐ No

6. Violated the drugs/device laws, rules, statutes and/or regulations of South Carolina, any other state, the United States, or any other country? ☐ Yes ☐ No

Permit Holder: _____
(Name)

Permit Holder Title: _____

Phone No.: _____ Email: _____

Pharmacist-in-Charge: _____

PIC License No.: _____ Email: _____

Pharmacist to technician ratio: _____

ATTESTATION

I hereby certify that the pharmacy, for which this permit is sought, will be conducted in full compliance with the statutory laws of this State pertaining to pharmacy and that the pharmacy will be under the supervision of a licensed pharmacist as required by law.

Permit Holder Signature _____ Date _____

I hereby certify that as Pharmacist-in-Charge, I will be responsible for the operation of this pharmacy in conformance with all laws pertinent to the practice of pharmacy and distribution of drugs and will be in full and actual charge of the pharmacy and personnel.

Pharmacist-In-Charge Signature _____ Date _____

PRIVACY NOTICE

South Carolina law requires the agency to collect personal information which is only disseminated as required by law. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on your renewal application and other documents on file may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical purposes.

CERTIFICATION STATEMENT

This affidavit is to be completed by the Pharmacist-in-Charge of a Central Fill Pharmacy Permit. S.C. Code Ann §40-43-195(H)(1)(d)

I certify that I have read and understand the laws and regulations relating to a central fill pharmacy in South Carolina.

Name of Pharmacy: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Pharmacist-In-Charge Signature _____ Date _____

Pharmacist-In-Charge Printed Name _____

Sworn and subscribed before me this _____ day of _____ , 20_____ .

Notary Signature: _____ *(SEAL)*

Print Notary Name: _____

Notary Public for the State of: _____

Commission Expiration Date: _____