



STATE BOARD OF PHARMACY

800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056
pharmacy@ks.gov Fax (785) 296-8420

**REGISTRATION APPLICATION:
Outsourcing Facility
Form BA-20**

All applications must be typed, be complete, and include all fees and supporting documentation before they will be processed by staff.

WHEN TO USE THIS FORM

Use this form if the facility is shipping to entities other than a patient. If shipping patient specific prescriptions, the facility must also be registered as a non-resident pharmacy using the BA-22 form.

FEES

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of \$350.00. Fees are nonrefundable.

INSTRUCTIONS

The following documents are required for the application to be complete:

- Copy of current outsourcing registration or permit issued by state of residence
- Copy of current pharmacy registration or permit issued by state of residence (if applicable)
- Copy of valid FDA registration as an outsourcing facility as required by 21 U.S.C. § 353b
- Facility inspection report conducted at current physical location by state of residence or National Association of Boards of Pharmacy (NABP) within the past 3 years
- Outsourcing inspection report from the FDA within the prior 24 months
- List of any other Kansas permit numbers
- List of registrations or permit numbers held by the facility in other states
- List of all trade or business names used by the owner
- List of all manufacturers, wholesale distributors, third party logistics providers, outsourcing facilities, and dispensers with which applicant is doing business in Kansas
- Detailed explanation of applicant's experience in the manufacture or distribution of prescription drugs (including controlled substances) and/or devices
- Surety Bond
- S-350 Non-Resident Information form
- S-300 Disciplinary History form and explanation documents if any Discipline Information questions are answered "yes"
- S-310, S-320 or S-330 ownership forms and/or business organizational chart, along with supporting documents (refer to top of individual forms for requirement). See Ownership information below for further detail.

OWNERSHIP

The Owner is the lowest level legal entity. If the Owner is a partnership, LLC or corporation, please complete and attach the appropriate **Ownership Form** (S-310 Partnership, S-320 LLC, or S-330 Corporate). If owned by other LLCs, partnerships, holding companies, corporations, etc., please submit information down to a person level of ownership.

Please indicate if this is a new application or a change:

- New Application Change (Check all that apply): Address Ownership Name
 Registration number: _____ Effective date of change: _____

OWNER INFORMATION

Name			
Address			
City	State	Zip	County
Phone	Fax		Email*
Ownership Type:			
<input type="checkbox"/> Individual Provide SSN: _____ <input type="checkbox"/> Government Entity Provide FEIN: _____			
<input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Corporation			
Complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate)			

Initials: _____	OFFICE USE ONLY		
Permit #: _____	Fee: \$ _____	Date: _____	Check #: _____

**STATE BOARD OF PHARMACY**

800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056
pharmacy@ks.gov Fax (785) 296-8420

**REGISTRATION APPLICATION:
Outsourcing Facility
Form BA-20**

*In accordance with K.S.A. 77-531(a)(3), Applicant consents to service via electronic mail. Service by electronic mail is complete upon transmission.

FACILITY INFORMATION

Name			
Physical Address (non-residential, no PO Box)			
City	State	Zip	County
Phone	Fax		Email
Website			NABP e-Profile ID
Facility Hours of Operation		Hours/Week Pharmacist on Duty	

DESIGNATED REPRESENTATIVE INFORMATION-This should be an individual preferably located at the facility.

Name		Title	
Address			Date of Birth
City	State	Zip	County
Phone	Fax		Email

AUTHORIZED RESIDENT AGENT INFORMATION (Per K.A.R. 68-7-12a, must be filed with Kansas Secretary of State)

Name		Title	
Address			
City	State	Zip	County
Phone	Fax		Email

Designate where all formal correspondence, notices, and renewals should be sent (mark only one):

Owner Physical Location Designated Representative Authorized Resident Agent

PHARMACIST-IN-CHARGE

Name	Kansas License Number	All non-resident pharmacies must have a Kansas-licensed pharmacist in charge per K.A.R. 68-7-12a.
Phone	Fax	Email

Yes No **Has the PIC ever been a PIC in Kansas before?**

If yes, Pharmacy Name: _____ License Number: _____



STATE BOARD OF PHARMACY

800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056
pharmacy@ks.gov Fax (785) 296-8420

**REGISTRATION APPLICATION:
Outsourcing Facility
Form BA-20**

DRUG SCHEDULES

If the facility holds a DEA registration, please select Drug Schedules below.

- Schedule II narcotic
- Schedule II non-narcotic
- Schedule III narcotic
- Schedule III non-narcotic
- Schedule IV
- Schedule V
- Other: _____

If any Drug Schedules were selected above, please provide either:

- A copy of the current DEA Registration
Current DEA Registration Number _____ Expiration Date: _____
- The submission date for the pending DEA Registration Application _____

DISCIPLINARY INFORMATION

Applicant includes the legal ownership entity as well as each individual, owner, partner, corporate officer, director, facility manager, or designated representative.

- Yes No 1. Has the applicant been convicted under any federal, state, or local law relating to drug samples, wholesale or retail drug distribution, manufacturing, dispensing, or distribution of any drug or controlled substance?
- Yes No 2. Has the applicant or the PIC been convicted of or entered a plea of no contest to any felony?
- Yes No 3. Has any license or registration, currently or previously held by the applicant or the PIC been denied, disciplined, censured, revoked, suspended, or surrendered for the dispensing, manufacture or distribution of any drug or controlled substance?
- Yes No 4. Has the applicant ever furnished false or fraudulent material on any application made in connection with the dispensing, manufacture or distribution of any drug?

If yes to any of the above questions, please attach Form S-300: Disciplinary History.

- Yes No 5. Has the applicant complied with all registration requirements under any previous or current licenses or registrations?
- Yes No 6. Has the applicant complied with all requirements to maintain and make available to the Board or to any federal, state, or local law enforcement officials those records required by the Food, Drug, and Cosmetic Act?
- Yes No 7. Has each employee or associate engaged in any distribution activity had education, training, or experience sufficient for that individual to perform assigned functions in such a manner as to provide assurance that the product, quality, safety, and security will at all times be maintained as required by any federal or state law?
- Yes No 8. Has the applicant conducted a background check and fingerprinting of each facility manager and designated representative and put protections in place to ensure that no owner, designated representative, facility manager, or employee has been convicted of any felony related to prescription only drugs or devices, any felony violation of 21 U.S.C. 331, or any felony violation of 18 U.S.C. 1365 related to product tampering?

If no to any of the above questions, please attach a detailed explanation along with any relevant documentation.



STATE BOARD OF PHARMACY

800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056
pharmacy@ks.gov Fax (785) 296-8420

**REGISTRATION APPLICATION:
Outsourcing Facility
Form BA-20**

PIC CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge (PIC) of the facility listed on this form, and I hereby accept responsibility for ensuring that all facility operations, supervision, and personnel are in compliance with all relevant state and federal laws and regulations, which shall include the Kansas Pharmacy Act, the Kansas Controlled Substances Act, and the Kansas Prescription Monitoring Program Act; that I am responsible for all PIC duties outlined in such laws and regulations.

SIGNATURE

DATE SIGNED

DESIGNATED REPRESENTATIVE CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I understand any permit issued will be issued jointly to the applicant and myself, and I hereby accept responsibility as the designated representative for such permit, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act and ensuring that prescription-only drugs and devices are distributed only to registered entities with the authority to possess prescription-only drugs or devices in Kansas.

SIGNATURE

DATE SIGNED

OWNER CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand this application and that the information provided is true, correct, and complete to the best of my knowledge.

SIGNATURE

DATE SIGNED