

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

WAIVER REQUEST: Electronic Prescribing KSA 65-16,128 Form C-700

INSTRUCTIONS

STATE OF KANSAS WAIVER ONLY

K.S.A. 65-16,128. Electronic transmission of prescription orders required, when; exceptions.

(b)(1) A prescriber may request a waiver from the provisions of subsection (a) for a period not to exceed six months if such prescriber cannot comply with subsection (a) due to economic hardship, technological limitations that reasonably are not within the prescriber's control, or other circumstance demonstrated by the prescriber.

You have the burden of proving that a waiver is appropriate and should be granted under the circumstances. Provide any additional documents that explain to the Board why you should be granted a waiver. Failure to do so may result in your request being marked incomplete, delayed review of your waiver, or denial. You may email, fax, or mail the form and supplemental documents to the Board office.

If a waiver is granted by the Board of Pharmacy, the prescriber may request that such waiver be renewed for a period not to exceed six

		30 th and December 31 st of each year.		
PRESCRIE	ER INFORMATION			
Prefix	First Name	Middle Initial	Last Name	
Direct Phone Number		Email Address	Email Address	
Kansas License Number		Kansas Licensing Ag	Kansas Licensing Agency	
REASON F	OR REQUEST			
□ Economi	c Hardship: Supporting statem	ent and documents must include th	e most recent tax return or other business	
	records that show	gross receipts and net profits.		
□ Technolo	gical Limitations: Supporting s	tatement and documents must be p	provided.	
□ Other: Sເ	upporting statement and docur	ments must be provided		
	LOCATION INFORMATION de a list of the practice location n	ames and addresses for which the wa	iver is requested:	

		OFFICE USE ONLY	
Approved / Denied	Initials:	Effective Date: <u>7/1/2021</u>	_Expiration Date:



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STATEMENT Attach additional supporting documents if needed to support entire statement.				
PRESCRIBER VERIFICATON The information contained on this form is true, correct, and complete to the best of my knowledge.				

PRESCRIBER SIGNATURE

DATE SIGNED