Kansas	**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.

REQUIREMENTS FOR NON-RESIDENT FACILITY

Attach a copy of the **current outsourcing and pharmacy registrations,** the **most recent inspection report** conducted within the past three years by the state of residence or the National Association of Boards of Pharmacy, **a list of registration or permit numbers** held by this facility from other states, and the **S-350 Non-Resident Information form**.

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.
Submit a list of all trade or business names used by the owner.

SUPPLEMENTAL INFORMATION

Please provide **a list** of all manufacturers, wholesale distributors, third-party logistics providers, outsourcing facilities, and dispensers with which the registrant is transacting business; **a detailed explanation** of the applicant's experience in the manufacture or distribution of prescription drugs, including controlled substances; a **current outsourcing facility registration**; and an outsourcing facility **inspection report from the FDA** within the prior 24-month period.

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:

☐ Individual Provide SSN: _____ ☐ Government Entity Provide FEIN: _____

☐ Partnership ☐ LLC ☐ Corporation

Complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate)

FACILITY INFORMATION

Name			Other Kansas registration number(s) held by this facility
Physical Address (non-residential, no PO Box)			
City	State	Zip	County
Phone	Fax		Email

Initials: _____ **OFFICE USE ONLY**

Permit #: _____ Fee: $_____ Date: _____ Check #: _____

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FACILITY INFORMATION Continued

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:

☐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: _____

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_____

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REGISTRATION APPLICATION:
Outsourcing Facility
Form BA-20

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.

PIC CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge acting on behalf of the applicant, and I hereby accept responsibility for operating in compliance with all state and federal laws, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act.

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 _____