



Idaho State Board of Pharmacy

PO Box 83720 Boise, Idaho 83720-0067 | Phone: 208-334-2356 | Fax: 208-334-3536
1199 Shoreline Lane Ste 303 Boise, Idaho 83702-9103 | <http://bop.idaho.gov> | info@bop.idaho.gov

Instructions & Required Documents for Idaho Prescriber Drug Outlet Registration

Please note- Prescriber Drug Outlet must be inspected before dispensing can occur

The following requirements must be met with submission of the application:

1. Complete the on-line application - all fields are required. Blank fields will delay processing

Prescriber in Charge must be designated-

For facilities dispensing controlled substances, prescriber must have a Practitioner of Controlled Substance Registration for that physical address.

OR

For facilities not dispensing controlled substances, prescriber in charge must have authority to prescribe legend drugs.

2. List of all prescribing practitioners – complete all fields
3. List of suppliers – complete all fields
4. If not dispensing controlled substances complete and upload a 'Certification of No Dispensing of Controlled Substance' form.

Otherwise, reporting applies as indicated below;

IDAPA27.01.01.204. CONTROLLED SUBSTANCES -- PMP.

Specified data on controlled substances must be reported weekly, or more often as required by the Board, by all pharmacies holding a DEA retail pharmacy registration that dispense controlled substances and prescribers that dispense controlled substances. Data on controlled substance prescription drug samples does not need to be reported. (3-21-12)

Contact Person for reporting: Teresa Anderson at Teresa.Anderson@bop.idaho.gov or 208.334.2356.

For all rules pertaining to dispensing of legend drugs including controlled substances, please refer to Idaho Code Title 54 and Rules IDAPA 27 Chapter 3.



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Prescription Monitoring Program AWA^Rx^E
1199 Shoreline Lane Suite 303/PO Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356/Fax: (208) 334-4814

Certification of No Dispensing of Controlled Substances Prescriber Drug Outlets

Please provide the information requested below. (Print or Type) Use full name not initials			
Name of Prescriber Drug Outlet			
Idaho Prescriber Drug Outlet License Number		Prescriber DEA Number	
Street Address		City	State Zip
Email Address		Telephone Number	Fax Number
Prescriber Drug Outlet Owner		License Number of Owner	
By signing this form I certify that:			
<ul style="list-style-type: none"> • My office does not currently deliver any drugs covered by the program (Schedule II, III, IV or V controlled substances) to patients. • If our business practice changes regarding dispensing drugs covered by the program to patients, we will immediately notify the Idaho Board of Pharmacy and begin submitting as required by Idaho Rule 204. • My office will resubmit this form every year with our prescriber drug outlet license renewal in order to recertify that the office does not deliver any drugs covered by the program to patients. 			
Signature:		Date:	
If approved, this form removes the requirement of zero reporting to the Idaho Prescription Monitoring Program until your next licensing renewal date, unless you begin dispensing controlled substances to ultimate users who have an Idaho address.			

For Board of Pharmacy Use Only			
Date Received:	Approved Disapproved	BOP Signature	Date of Action
Notes:			