



## **STERILE COMPOUNDING PHARMACY LICENSE APPLICATION INSTRUCTIONS**

(Business & Professions Code Sections 4127 and 4127.1)

A California pharmacy shall not compound sterile drug products unless the pharmacy has obtained a sterile compounding pharmacy license from the Board pursuant to Business and Professions Code Sections 4127 and 4127.1. The license shall be renewed annually and is not transferable.

A license to compound sterile drug products may not be issued or renewed until the location is inspected by the Board and found to be in compliance with the Business and Professions Code and regulations adopted by the Board.

All pharmacies that compound sterile drug products must follow Board regulations for sterile compounding found in the California Code of Regulations beginning with section 1751.

**IMPORTANT:** Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. If the number of forms included in this application is insufficient, please make copies. Please allow approximately 45 days from the date your application is submitted before checking on the status. The contact person designated on the application will be advised if additional information is necessary.

A checklist is provided with these instructions. The Board encourages the submission of all required documentation with the application as well as the use of the checklist to assist with the application process. The Board may request additional documentation to confirm or substantiate information in the application. When submitting documents to the Board, please make a copy for your records.

### **CHECKLIST FOR FILING A STERILE COMPOUNDING PHARMACY APPLICATION**

Use this checklist to ensure your application is complete prior to submitting. If the application is not complete, the Board will notify you of any deficiencies. Failure to complete your application within 60 days after being notified of deficiencies will result in the application being deemed abandoned. You will then be required to file a new application and meet all of the requirements in effect at the time of reapplication.

**1. EFFECTIVE APRIL 1, 2020, THE APPLICATION PROCESSING FEE IS \$2,305.**

Include a check or money order made payable to the California State Board of Pharmacy. This fee is nonrefundable. (NOTE: A government owned pharmacy is fee exempt.)

- **Effective April 1, 2020, the temporary license fee is \$715.** To apply for a temporary license, an additional fee of \$715 must be submitted in addition to the application processing fee and the temporary application (17A-116). When a change of ownership occurs, a temporary license must be requested or **ALL** operations requiring a sterile compounding license must cease. If a temporary license is not requested, **OPERATIONS MUST STOP** until a new license to compound sterile drug products is obtained. This fee is nonrefundable.

**2. STERILE COMPOUNDING PHARMACY APPLICATION (form 17A-48):** Complete the entire application and submit with original signatures. Scanned or stamped signatures are not accepted.

**3. CHANGE OF OWNERSHIP / LOCATION**

A sterile compounding pharmacy license is nontransferable. A license is issued to the owner(s) and for the location of the facility. All approved change of ownership and change of location applications will result in a new license number being issued. Operating the facility prior to a new license being issued is unlicensed activity and may result in denial or disciplinary action by the Board.

**Change of Ownership Documentation:** In addition to these application requirements, an application for the primary pharmacy must be submitted along with all the required documentation identified in the instructions for the appropriate primary application.

**4. POLICIES AND PROCEDURES** - A copy of the pharmacy's proposed policies and procedures for sterile compounding electronically (i.e. flashdrive, CD, email, etc.). If emailing the policies and procedures, please send to [compounding.pharmacy@dca.ca.gov](mailto:compounding.pharmacy@dca.ca.gov).

**5. SELF-ASSESSMENT FORM:** A copy of the pharmacy's self-assessment may be submitted electronically (i.e. flashdrive, CD, email, etc.). If emailing the policies and procedures, please send to [compounding.pharmacy@dca.ca.gov](mailto:compounding.pharmacy@dca.ca.gov).



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Business, Consumer Services and Housing Agency  
 Department of Consumer Affairs  
 Gavin Newsom, Governor



## STERILE COMPOUNDING PHARMACY LICENSE APPLICATION

### 1. Applicant Information (Name of license cannot exceed 65 characters including spaces)

\_\_\_\_\_  
 Name of Pharmacy License Number

\_\_\_\_\_  
 Address of Pharmacy:    Street City State Zip Code

\_\_\_\_\_  
 Exact Location of Sterile Compounding Pharmacy (Room Number or Name of Room)

\_\_\_\_\_  
 Pharmacy Telephone Number Sterile Compounding Pharmacy Telephone Number

Please provide the mailing address to receive correspondence while the sterile compounding pharmacy application is pending, if different than the address listed above. When the license is issued, all correspondence will be sent to the pharmacy address.

\_\_\_\_\_  
 Mailing Address, if different than above    Street City State Zip Code

### 2. Type of Application

\_\_\_ New Sterile Compounding Pharmacy License \_\_\_\_\_ Anticipated Opening Date  
 \_\_\_ Change of Ownership \_\_\_\_\_ Anticipated Change of Ownership Date  
 \_\_\_ Change of Location \_\_\_\_\_ Anticipated Move Date

### 3. Type of Ownership Provide the FEIN # (Federal Employer ID #) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_ Individual                      \_\_\_ Partnership                      \_\_\_ Limited Liability Company    \_\_\_ Trust  
 \_\_\_ Corporation                      \_\_\_ Nonprofit Corporation    \_\_\_ Publicly Traded                      \_\_\_ Government

**4. Contact Person:** The Board will ONLY discuss the status of this application with the person identified as the contact person and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. An authorized owner may designate additional individuals to receive information on this pending application by submitting the Authorization to Release Applicant Information form. The Board may communicate deficiencies and status of application to the contact person via email.

\_\_\_\_\_  
 Name of Contact Person Telephone Number Email Address

#### For Board Use ONLY

Date Processed: \_\_\_\_\_ Date Issued: \_\_\_\_\_ Date Cashiered: \_\_\_\_\_  
 Processed by: \_\_\_\_\_ Issued by: \_\_\_\_\_ Cashiering #: \_\_\_\_\_  
 Amount Received: \_\_\_\_\_

**5. Change of Ownership or Location** Provide the exact name, address, location, and license number as listed on the current sterile compounding pharmacy license.

\_\_\_\_\_  
Name listed on the Current Sterile Compounding Pharmacy License License Number

\_\_\_\_\_  
Address: Street City State Zip Code

\_\_\_\_\_  
Exact Location of Sterile Compounding Pharmacy (Room Number or Name of Room)

\_\_\_\_\_  
Expiration Date of License Effective Date of Change of Ownership/Location

**6. Pharmacist-in-Charge (PIC) of Licensed Pharmacy** List the Pharmacist-In-Charge (PIC) to serve as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. The PIC must be approved by the board.

\_\_\_\_\_  
Name of PIC Pharmacist License Number

\_\_\_\_\_  
Telephone Number of PIC Email Address

*I certify that the policies and procedures of the sterile compounding are consistent with California Code of Regulations Title 16, section 1735 et seq and 1751 et seq. (A copy of the pharmacy's proposed policies and procedures for sterile compounding must accompany the application.)*

\_\_\_\_\_  
Original Signature of PIC Date

**7. Compounding to be Performed:** (Check all that apply)

Type of compounding performed:	Type of Products to be compounded:
<input type="checkbox"/> Non-sterile to sterile	<input type="checkbox"/> Injectable
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Inhalation
<input type="checkbox"/> Sterile to Sterile	<input type="checkbox"/> Ophthalmic
<input type="checkbox"/> Radiopharmacy	

Number of Hoods/Barrier Isolators: \_\_\_\_\_

Do you perform centralized packaging for unit dose packaging? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide the license number for the centralized hospital packaging location. \_\_\_\_\_

**PLEASE READ CAREFULLY**

This application must be approved by the California State Board of Pharmacy before a sterile compounding pharmacy license will be issued.

If changes are made during the application process, the applicant may need to submit a new application with appropriate fees. **Any application not completed within 60 days after being notified by the Board of deficiencies may be deemed to have been abandoned, and the applicant will be required to file a new application and meet all the requirements that are in effect at the time of application. Fees applied to this instant application are not transferable or refundable.**

Failure to provide any of the requested information may result in the application being considered incomplete. Any material misrepresentation in the answer of any question is grounds for denial or subsequent revocation of the license and is a violation of the California Penal Code.

The information will be used to determine qualifications for licensure under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, (916) 518-3100, located at the Board's address. The information may be transferred to another governmental agency, such as a law enforcement agency, if necessary, to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential and exempted by Civil Code section 1798.38.

\*Disclosure of your social security number if you are a sole proprietor or federal employer identification number ("FEIN") if you are a partnership is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes or compliance with any judgment or order for family support in accordance with section 17520 of the Family Code. If you fail to disclose your social security number or your FEIN, your application for initial or renewal license will not be processed AND you may be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

\*\*Residence address will not be made available to the public.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share individual taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if the state tax obligation is not paid.

Under penalty of perjury, under the laws of the State of California, the person whose signature appears below, certifies the primary pharmacy and sterile compounding pharmacy is under common ownership, is listed on the primary pharmacy application/license and is:

1. The **owner, partner, member, officer, director, manager, trustee, or the administrator (government owned)**, of the primary pharmacy named in the foregoing application, is duly authorized to make this application on its behalf and is at least 18 years of age.
2. Has read the foregoing application and knows the contents thereof and that each and all statements therein made are true.
3. No person other than the applicant or applicants has any direct or indirect interest or management and control in the applicant pharmacy business to be conducted under the license for which this application is made.

4. Understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license.
5. All supplemental statements are true and accurate.
6. A change of ownership application may be withdrawn by either the applicant or the licensee with no resulting liability to the California State Board of Pharmacy.

Provide original signature. Scanned, stamped or electronic signature may not be accepted.

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Signature

Print Name

Title

Date

**AUTHORIZATION TO RELEASE APPLICANT INFORMATION**

(Optional)

**Applicant Business Information – Please print or type**

File Number, if applicable \_\_\_\_\_

\_\_\_\_\_  
Name of Business Telephone Number of Business

\_\_\_\_\_  
Name of Business DBA if different than above

\_\_\_\_\_  
Address of Business – Street City State Zip Code

The Board will ONLY discuss the status of this application with the authorized person identified on the application and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. In order for the Board to discuss the status of this application with another individual, the authorized person identified on the application must authorize in writing the Board to discuss the application status with a his or her authorized representative.

Giving consent for the Board to disclose application and business information will authorize the Board to disclose all personal and business information pertaining to this application. This includes but is not limited to social security number, date of birth, address information, all application requirement information, application approval or denial status, and any criminal conviction information the Board may have on record for your application.

**Applicant Consent – Must be signed and dated by the applicant for optional authorization to be valid.**

As a person identified on the application that is authorized to act for and bind the applicant business, I hereby give the Board consent to communicate to the individual listed below.

I, \_\_\_\_\_, hereby give consent to  
Print Name of Person Authorized to Bind the Applicant Business

the California State Board of Pharmacy to disclose information about this application as specified above to the following individual:

\_\_\_\_\_  
Name Telephone Number Email Address

\_\_\_\_\_  
Mailing Address – Street City State Zip Code

This consent will expire on \_\_\_\_\_, within one year, or upon  
licensure, whichever comes first. (Date)

\_\_\_\_\_  
Original Signature of Person Authorized to Bind the Applicant Business Date