Nevada State Board of Pharmacy

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CANCER DRUG DONATION PROGRAM

DRUG DONATION, TRANSFER AND DESTRUCTION RECORD

Completion of this form meets the requirements of NRS Chapter 457 for the Cancer Drug Donation Program for donating drugs and for distribution of drugs to participating repository for drug destruction.

DONATION INFORMATION

Name- Donor (Print or Type)		Date of Birth
Address of Donor		Telephone Number
Name of Pharmacy that originally filled prescription		
Address of Original Pharmacy		
Pharmacy Telephone Number	Pharmacy Fax Number	Dispensing Pharmacist Name
Original Dispense Date	Original Prescription Number	Original Quantity Dispensed
Name-Pharmacy/Medical Facility/ Healthcare Clinic/Healthcare Provider receiving donation		
Name of Medication		
Medication Strength	Expiration Date/Lot Number	Quantity Donated

I certify that the above named drug was stored as recommended by the manufacturer and has not been tampered with.

SIGNATURE- Donor	Date Signed
Name of Pharmacist Receiving Medication to Pharmacy	Initial to indicate checklist completed
SIGNATURE- Pharmacist	Date Signed

NOTE-Please complete checklist on Page 2 upon receipt of medications and initial to indicate completion.

Return completed for to address listed in header.

CHECK TO ENSURE ALL REQUIREMENTS ARE MET OF TRANSACTION:

- ☐ Package Unopened (seal or tamper evident intact)
- ☐ Dispensed pursuant to an original prescription by a pharmacy licensed pursuant to Chapter 639 of NRS
- ☐ Expiration is not within 30 days of donation
- ☐ **NOT** a controlled substance
- ☐ **NOT** a compounded drug product
- ☐ **NOT** require refrigeration or freezing or other temperature requirements
- ☐ **NOT** part of a program of restrictive distribution as established by the manufacturer
- ☐ **NOT** part of an ongoing clinical trial or study

DRUG TRANSFER INFORMATION

Name-Pharmacy/Medical Facility/ Healthcare Clinic/Healthcare Provider receiving drug		
Address of Pharmacy/Medical Facility/Healthcare Clinic/Healthcare Provider receiving drug		
Telephone Number	Fax Number	
Name of Medication		Date Transferred
Medication Strength	Expiration Date/Lot Number	Quantity of Drug Transferred
Name of Pharmacist Receiving Medication to Pharmacy	Signature	
Name of Pharmacist Transferring Medication	Signature	

Copy or original donation form must be provided with transferred medication

DESTRUCTION INFORMATION

Name of Medication	Quantity Destroyed
SIGNATURE of Pharmacist Destroying Medication	Date Destroyed

Return completed for to address listed in header.