

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway, Suite 206 - Reno, NV 89521 - (775) 850-1440

PHARMACIST - CONTROLLED SUBSTANCE REGISTRATION APPLICATION

Non-Refundable \$200 fee

This application cannot be returned by fax or email. An original signature and fee are required to process.

NRS 639.28079 authorizes Nevada licensed pharmacists to apply for a Nevada Controlled Substance (CS) and DEA registration to prescribe and dispense dangerous drugs and certain Schedule III controlled substances (FDA-approved buprenorphine and buprenorphine combination products) for the treatment of Opioid Use Disorder (OUD). A pharmacist who has obtained the required registrations must comply with NRS 639.28079, the regulations promulgated ([R059-23AP](#)), and federal law as it pertains to the prescribing and dispensing of dangerous drugs and FDA-approved buprenorphine and buprenorphine combination products for the treatment of OUD, including, but not limited to, completing federally mandated training prior to prescribing. Additional information can be found by reviewing NRS 639, NRS 453, NRS 454, NAC 639, NAC 453, and 21 CFR part 1306.

NRS 453.232 A person who dispenses, prescribes, or administers a controlled substance without being registered by the Nevada State Board of Pharmacy (Board) is guilty of a CATEGORY D FELONY and shall be punished as provided in NRS 193.130.

Medication-assisted treatment – means treatment for an OUD using medication approved by the United States Food and Drug Administration for that purpose.

Please **COMPLETE in SEQUENTIAL ORDER** the following to obtain a controlled substance registration.

Step 1: Obtain your Nevada Prescription Monitoring Program (PMP) account

- A. Visit nevada.pmpaware.net, click "Create an Account", and follow the instructions on the webpage to complete your registration. For assistance contact the PMP at 775-687-5694 or pmp@pharmacy.nv.gov.
- B. If your PMP registration is approved, you will receive an automated email confirmation from "No Reply PMP Aware". It is a system-generated email so it may go into your spam or junk file. Once you receive this email proceed to **Step 2**.

Step 2: Submit your Controlled Substance (CS) Application

- A. Complete and mail the application that is **attached** to these instructions to the address indicated above with the required **non-refundable fee** of **\$200.00**. Fees can be paid for by credit card, debit card, personal check, cashier's check, or money order made payable to the **Nevada State Board of Pharmacy**. Credit and debit card payments are charged a **5% processing fee**.
- B. If your application is approved, you will receive an email with your CS registration. Proceed to **Step 3**.

Step 3: Obtain your Drug Enforcement Administration (DEA) Registration

NOTE: An active CS registration is required to complete this application.

- A. Complete the on-line DEA application at deadiversion.usdoj.gov. If you have a DEA number from another state, and want to transfer that DEA number to Nevada, you will need to complete the DEA Registration Change Requests form.
- B. If your application or form is approved by the DEA, you will receive your DEA certificate in the mail.
- C. You **MUST** email (pharmacylicensing@pharmacy.nv.gov) or fax (775-850-1444) a copy of your DEA certificate to the Board.

You are **NOT AUTHORIZED** to prescribe dangerous drugs or FDA-approved buprenorphine and buprenorphine combination products, for the treatment of OUD unless you have an active PMP account, an active CS registration, **AND** an active DEA registration (in which a copy of the certificate has been provided to the Board).

A CS registration expires **OCTOBER 31, OF EVEN NUMBERED YEARS**, despite when the registration is issued. You **MUST** notify the Board in writing of any changes to the location of your practice. NAC 453.280.

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Approval of this application and obtaining all the required registrations authorizes a pharmacist to prescribe and dispense dangerous drugs and certain Schedule III controlled substances (**FDA-approved buprenorphine and buprenorphine combination products**) for the treatment of OUD.

Section 1: Personal Information

First: _____ Middle: _____ Last: _____
 Date of Birth: _____ SSN or ITIN: _____ Sex: M F X
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Telephone: _____ Email: _____
 NV Pharmacist Registration #: _____

Section 2: Practice Information (A practice address is required for processing of your application.) Where will you be prescribing controlled substances and dangerous drugs for medication-assisted treatment?

Practice Name (if any): _____ Pharmacy license # (if applicable): _____
 Practice Address: _____ Suite #: _____
 City: _____ State: _____ Zip: _____
 Telephone: _____ Fax: _____ Email: _____

Section 3: Military Service (NRS 622.120)	Yes	No
1. Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
2. Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
3. Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		

Section 4: Federally Mandated Requirement (NRS 425.520, NRS 639.129)	Yes	No
1. Are you the subject of a court order for the support of a child? (If "yes", answer question 2.)		
2. Are you in compliance with the order or the plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order?		

Section 5: Personal and Professional History	Yes	No
1. Have you been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?		
2. Have you been charged, arrested or convicted of a felony or misdemeanor in <u>any</u> state?		
3. Have you been the subject of a board citation or an administrative action whether completed or pending in <u>any</u> state?		
4. Has your license been subjected to any discipline for violation of pharmacy or drug laws in <u>any</u> state?		

Please use and make copies of this page (if necessary) to provide information regarding any questions, 1-4, you have marked "YES" to in section 5 of the application. A signed statement of explanation for each event and a copy of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.

This is in response to Question # _____. Provide all the following *where applicable*:

Date of Event/Arrest	Disposition Date	State	City	County
Case #		Governing, licensing, Arresting Presiding Body/Agency/Court		
Reason/Charge				
Plaintiff/Defendant/Claimant/Respondent			Lawsuit/Arbitration/Bankruptcy	
Name of Business/Industry/Entity				

Provide explanation below:

Original Signature (electronic, copies or stamps not accepted)

Date

Section 6: Acknowledgement and Attestation

I _____ (your name) attest that I have read, understand, and agree to the following (**initial each statement below to indicate you have read, understand, and agree with the following**):

_____ I understand that I am not authorized to prescribe any dangerous drugs or **FDA-approved buprenorphine and buprenorphine combination products** for medication-assisted treatment unless I have an active PMP account, an active CS registration, AND an active DEA registration (in which a copy of the certificate has been provided to the Board).

_____ I understand that by obtaining a CS registration to prescribe dangerous drugs and **FDA-approved buprenorphine and buprenorphine combination products** for medication-assisted treatment, I now fall under the definition of “practitioner” in NRS 453.126, NRS 639.0125, and NRS 454.00958 and must comply with all federal and state laws pertaining to the prescribing of dangerous drugs and controlled substances for a “practitioner” in NRS 639, NRS 453, NRS 454, NAC 639, NAC 453, NAC 454, and 21 CFR part 1306.

_____ I understand that, if I am granted a CS registration, I am only permitted to prescribe dangerous drugs and **FDA-approved buprenorphine and buprenorphine combination products** for the treatment of a patient with an OUD. The dangerous drugs and **buprenorphine and buprenorphine combination products** I prescribe must be approved by the United States Food and Drug Administration.

_____ I understand that, if I am granted a CS registration, I am only permitted to *prescribe* dangerous drugs and **FDA-approved buprenorphine and buprenorphine combination products** for medication-assisted treatment, and I am **NOT permitted** to *possess, dispense or administer* medication-assisted treatment unless I work for a Nevada licensed pharmacy and the dispensing and administration of these medications occur in a Nevada licensed pharmacy (certain exclusions apply).

_____ I understand that, if I am granted a CS registration, before counseling and providing information to a patient concerning evidence-based treatment for OUD, including, without limitation, medication-assisted treatment; and prescribing a drug for medication-assisted treatment, I must:

1. Assess the patient to determine whether:
 - a. The patient has an OUD; and
 - b. Medication-assisted treatment would be appropriate for the patient
2. Document the assessment in the record of the patient.

_____ I understand that, if I am granted a CS registration, before I offer medication-assisted treatment to a patient, I shall establish a documented treatment plan tailored to the needs of the patient. The documented treatment plan must include, without limitation:

1. A procedure for evaluating the progress or success of the treatment with stated objectives, including, without limitation, improved physical or psychosocial function; and
2. Consideration of pertinent medical history, previous medical records and physical examination and the need for further testing, consultations, referrals, or the use of other treatment modalities.

_____ I further understand that I may only provide medication-assisted treatment in accordance with the documented treatment plan established.

_____ I understand that, if I am granted a CS registration, and provide medication-assisted treatment to a patient, I shall document and conduct periodic reviews of the care of the patient. The periodic reviews must be conducted at reasonable intervals in consideration of the individual circumstances of the patient and include, without limitation:

1. Consideration of the individual circumstances of the patient;
2. Any progress in reaching the objectives of the treatment; and
3. Consideration of the treatment prescribed, ordered, or administered, as well as any new information about the etiology of the OUD of the patient.

_____ I understand that, if I am granted a CS registration, and provide medication-assisted treatment to a patient, I shall maintain complete and accurate records of the medication-assisted treatment provided to a patient, including, without limitation, any records required pursuant to chapter 639 of NRS and the regulations adopted pursuant thereto. I must make all records maintained available for review upon request of the Board.

_____ I attest I have completed the federally required training to prescribe controlled substances and dangerous drugs for medication-assisted treatment.

I certify under penalty of perjury that the information contained in this application is accurate, true and complete in all material respects. I understand that making any false representation in this application is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this entire application and any portion thereof is a public record unless otherwise declared confidential by law, and will be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020. In the event this application is approved I agree to comply with all applicable federal and state statutes and regulations governing this license or registration and understand that any violation may result in discipline.

Print Name (First, Last)

Original Signature (electronic, copies or stamps not accepted)

Date

Board Use Only: Date Processed: _____ Amount: _____



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985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

(775) 850-1440 • (800) 364-2081 • FAX (775) 850-1444

• Web Page: bop.nv.gov

Applicant Name: _____

Payment: Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**.

Credit cards are charged a 5% processing fee.

Credit Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express	Credit Card #: _____	
Expiration Date: ____/____ (MM/YY)	CVV (3 digits on back of card):	Amount: \$ _____
Name on Card: _____		
Billing Address: _____ _____ _____		