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

Rev (04/24/2024)

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

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 opioid use disorder 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. Approval of this application and issuance of a controlled substance registration authorizes the applicant to assess a patient to determine whether the patient has an opioid use disorder, and if medication-assisted treatment would be appropriate for the patient, prescribe controlled substances or dangerous drugs for medication-assisted treatment. Failure to complete all the requirements could result in disciplinary action.

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 controlled substances or dangerous drugs 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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Select the Controlled Substance Schedules you are applying to prescribe.

☐ Schedule I ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

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 any state?		
3. Have you been the subject of a board citation or an administrative action whether completed or pending in any state?		
4. Has your license been subjected to any discipline for violation of pharmacy or drug laws in any 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 controlled substances 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 controlled substances 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 the statutes and regulations pertaining to the prescribing of dangerous drugs and controlled substances for a "practitioner" in NRS 639, NRS 453, NRS 454, NAC 639, NAC 453, and NAC 454, inclusive.

___________ I understand that, if I am granted a CS registration, I am only permitted to prescribe dangerous drugs and controlled substances for the treatment of a patient with an opioid use disorder. The dangerous drugs and controlled substances 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*** controlled substances and dangerous drugs for medication-assisted treatment, and I am ***NOT permitted*** to ***dispense or administer*** controlled substances and dangerous drugs for medication-assisted treatment.

___________ I understand that, if I am granted a CS registration, before counseling and providing information to a patient concerning evidence-based treatment for opioid use disorders, 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 opioid use disorder; 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 opioid use disorder 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: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express	**Credit Card #:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	
Expiration Date: __ __/__ __ (MM/YY	**CVV** (3 digits on back of card): ______	**Amount**: $___________
Name on Card: ____		
Billing Address: ____ ____ ____		