MINNESOTA BOARD OF PHARMACY

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335 Randolph Ave., Suite 230 | St. Paul, MN 55102

Facility License Category Change Notification

In-State and Out-State Facilities

This change notification should be submitted within 30 days prior to adding or changing categories.

Facility Information

Full Legal Name of Business: _____ MN License #: _____

Federal Tax ID: _____ DEA Number (if applicable): _____

Effective Date of Change: _____ Contact Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Categories

Note: please download and open PDF in a dedicated viewer such as Acrobat Reader

Categories	Currently Licensed in Category?	Requested Action			Explanation for Change
	Yes	No Change	Remove	Add	
Active Pharmaceutical Ingredient (API)	☐			☐	
Controlled Substance	☐			☐	
Human Non-prescription (OTC)	☐			☐	
Human Prescription (Legend Drug)	☐			☐	
Human/Veterinary drug by Outsourcing Facility	☐			☐	
Medical Gas	☐			☐	
Veterinary Non-prescription (OTC)	☐			☐	
Veterinary Prescription (Legend Drug)	☐			☐	
Other: _____	☐			☐	
Opiate (See below)	☐			☐	

Required Items if adding Opiate Category:

Does the facility licensee hold the labeler code for an opiate-containing controlled substance? Yes No

DEA Registration Number (if applicable): _____

Labeler Code(s): _____

Is the $50,000.00 Opiate-manufacturer licensing fee included with this form?

Yes No

Provide explanation if you believe the Licensee has already paid this annual fee:

Categories Sold or Distributed

Select each category you will **sell** or **distribute** drugs or medical gas to:

- ☐ Ambulance
- ☐ Dentist
- ☐ Government
- ☐ Home Health Agency
- ☐ Home Health Care
- ☐ Hospital
- ☐ Manufacturer
- ☐ Nursing Home
- ☐ Patient Specific Prescriptions
- ☐ Pharmacy
- ☐ Practitioner
- ☐ Veterinary
- ☐ Wholesaler
- ☐ Other: _____

Certification and Signature

I, the undersigned, certify that I am authorized to submit this notification on behalf of the facility licensee. I certify that the information provided in this notification is true, accurate, and complete to the best of my knowledge, and that the facility will operate in compliance with all applicable federal and state laws, rules, and regulations.

Authorized Representative Name: _____

Title: _____

Email Address: _____

Signature of Authorized Representative: _____

Date Signed: _____

Upload this form using your online services account or submit by email to pharmacy.board@state.mn.us.