

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 *(Complete all that applies)*

Current Name/DBA Name as listed on the License	Effective Date	Current MN License #	Federal Tax ID	DEA Number
Street Address	City	State	Zip	Contact Number

Check all categories of drugs you currently handle.

- | | | |
|----------------------------|---------------------------------|-------------------------------------------|
| A. Human Prescription | B. Human Non-prescription (OTC) | C. Active Pharmaceutical Ingredient (API) |
| D. Veterinary Prescription | E. Veterinary Non-prescription | F. Human/Vet drug by Outsourcing Facility |
| G. Opiate | H. Medical Gases | I. Other _____ |
| J. Controlled Substances | | |

Indicate the category change(s) below.

Category	Add This Category	Delete This Category	Briefly Explain Reason for the Change
A. Human Prescription			_____
B. Human Non-prescription (OTC)			_____
C. Active Pharmaceutical Ingredient			_____
D. Veterinary Prescription			_____
E. Veterinary Non-prescription			_____
F. Human/Vet Drug by Outsourcing			_____
G. Opiate*		DEA #: _____	_____
H. Medical Gases			_____
I. Controlled Substances			_____
J. Other (Indicate type)			_____

The Board may contact you for additional information if necessary.

Drug Manufacturers adding an Opiate Category and holding the rights to the product must include the Opiate licensing fee of \$50,000.00 and their DEA # with this form. Checks or money orders should be made payable to: **Minnesota Board of Pharmacy*

I, the undersigned, do hereby certify that all of the information contained in notification is true and correct, and that the firm will be operated in compliance with all applicable laws and regulations.

Authorized Signature	Printed Name	Date
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All forms can be submitted through postal mail, fax, or email

Minnesota Board of Pharmacy
335 Randolph Avenue, Suite 230 | Saint Paul, MN 55102
Fax: (651) 215-0951 | E-mail: pharmacy.board@state.mn.us

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