DSHS Family & Community Health Services Division
Class D Pharmacy License Exemption Request

PART I – AGENCY/CLINIC INFORMATION

Agency Name				
Clinic Name				
Clinic Address (Street or P.O. Box)	City	County	State	ZIP
Contact Name	Contact Telephone Number	Contact Email Address		

PART II – PHARMACY REFERRAL PROCESS

Briefly describe the process through which patients will obtain medications from referral pharmacy/pharmacies. Include:

a) location of referral pharmacy/pharmacies in relation to clients and clinic site,
b) discussion of elimination of barriers to clients receiving medications, and
c) how the agency/clinic will ensure that clients will not incur additional costs to obtain medication.

PART III – PHARMACY EXEMPTION JUSTIFICATION

Briefly provide justification of the benefits to the agency and/or clients for requesting a Class D pharmacy license exemption.

PART IV – MEMORANDUM OF UNDERSTANDING (MOU)

Provide a copy of a signed and fully executed MoU with the referral pharmacy/pharmacies. The MoU must include the purpose of cooperation and detail coordination between the agency/clinic and referral pharmacy/pharmacies to provide the following medications:

a) non-clinician administered hormonal contraceptive methods (oral contraceptives, transdermal hormonal contraceptives "patch", or vaginal hormonal contraceptives "ring");
b) anti-infectives for the treatment of STIs and other infections; and
c) other medications necessary to treat health care needs of the client population.

PART V – POLICY

Provide a copy of the agency's/clinic's policy that ensures clients can obtain prescribed medication refills from the cooperating pharmacy/pharmacies without an additional clinic visit (unless medically indicated/necessary).

The facts affirmed by me in this waiver request are truthful and, as the authorized representative of the agency named above, I warrant that the agency will follow all procedures outlined above for the provision of pharmaceuticals to eligible clients.

_____ _____
Signature Date

DSHS AUTHORIZED USE ONLY

Class D Pharmacy Exemption Granted: ☐ Yes ☐ No

_____ _____
Signature Date