



OKLAHOMA STATE BOARD OF PHARMACY

2920 N Lincoln Blvd, Ste A, Oklahoma City, OK 73105
Phone: (405) 521-3815 / Fax: (405) 900-8365
www.pharmacy.ok.gov / e-mail: pharmacy@pharmacy.ok.gov

FOR OSBP USE ONLY	
RECEIPT:	
DATE:	

2025-2026 NOTICE OF RENEWAL OF PHARMACY LICENSE

A. License #: _____

List Name, DBA, and Business Physical Address:

DUE UPON RECEIPT

ONLINE ONLY

<https://pay.apps.ok.gov/OSBP/payments/>

Fee doubles 15 days after expiration

EXPIRATION DATE: _____

[See Section B for license renewal fee and add any permits currently held by pharmacy for total due]

Pharmacy License Renewal - \$ _____

Training Area Permit Renewal- \$10.00

Drug Supplier Permit Renewal- \$20.00

Sterile Compounding Permit Renewal- \$75.00

TOTAL AMOUNT DUE- \$ _____

B. Type of Pharmacy (✓ check one)	CHARITABLE: \$75			
	HOSPITAL: \$150			
	HOSPITAL DRUG ROOM : \$40			
	NON-RESIDENT: \$150	FOR RESIDENT & NON-RESIDENT PHARMACIES:		
	RETAIL: \$150	Independent	Chain	Clinic
		Closed Door	Nuclear	Other
	IN-STATE RMOP (Remote Medication Order Processing) for Hospitals: \$150			
	NON-RESIDENT RMOP (Remote Medication Order Processing) for Hospitals: \$150			

C. Pharmacy Information:

Pharmacy Phone: _____ Fax: _____ E-mail: _____

Pharmacy hours: Mon – Fri _____ Saturday _____ Sunday _____

Pharmacist In Charge Email: _____ (Any notice of deficiencies will be sent to PIC via email)

D. Designated Pharmacist-In-Charge (Oklahoma licensed PIC required):

By my signature, I acknowledge that I am employed by the pharmacy named above and that I am the pharmacist-in-charge. I certify that I am a licensed pharmacist in the State of **Oklahoma**. My business practices will conform to the laws and rules of the United States and the pharmacy laws and rules of the State of Oklahoma and I acknowledge my requirement to abide by OAC 535:15-3-2.

Printed Name: _____ OK Lic # _____ Signature: _____

E. Does this pharmacy have a written Drug Diversion Detection and Prevention Policy on file and available for review as required by OAC 535:15-3-2? ___ Yes **(REQUIRED)**

F. Hospital & Hospital Drug Room Information: [N/A ___]

1. # of Beds: _____ 2. Hospital Drug Room designated **Drug Room Supervisor** (DPh, RN or LPN): _____

Printed Name & Title: _____

G. Retail & Non-Resident Pharmacy Information: [N/A ___]

1. Does this pharmacy compound sterile drug products? ___ Yes ___ No [This question **MUST** be answered – DO NOT mark N/A if this is a retail or non-resident pharmacy]

a) If Yes, what is the compounding risk level? _____

b) If Yes, are all prescriptions patient specific? ___ Yes ___ No

1. If not patient specific, are you compounding sterile drugs for Veterinarian office use? Yes No

2. If no, please apply for an Outsourcing Facility license.

H. If this Pharmacy is NOT LOCATED IN OKLAHOMA, the following must be submitted with this application: [N/A ___]

- Copy of Valid Home State License (Must provide copy of actual license, online verification printout will not be accepted)
- Copy of most recent inspection report (Conducted by home state, NABP, or FDA)
- Current Description of Operations
- Policies & Procedures for: a) Storage of Medications, b) Shipping of Medications, c) Temperature Excursions
- List any and all temperature excursions on shipped medications for the last five (5) years <if not currently tracking, please start immediately>

I. **CDS INVENTORY MUST BE INCLUDED FOR ALL RESIDENT PHARMACIES.**

Pursuant to OAC 535:15-3-10(b), "An inventory of all controlled dangerous substances (CDS) must be taken between May 1 and July 1 of each year. A copy of this inventory will be included with the pharmacy renewal application."

J. Please provide the following (you may put N/A if not issued for this pharmacy): _____

1. NCPDP #: _____ 3. OK Bureau of Narcotics #: _____

2. NPI #: _____ 4. DEA #: _____

K. Licensed Pharmacists and Technicians employed by this pharmacy: (attach additional sheet if necessary)

***FAILURE TO INCLUDE ALL LICENSED STAFF ON THIS RENEWAL MAY PREVENT THEIR ABILITY TO RENEW-**

Cert. #	Pharmacists (Print Name) (Include Interns in this column)	Full Time	Part Time	Permit #	Technicians (Print Name)	Full Time	Part Time

L. Ownership:

	SOLE PROPRIETOR		CORPORATION		GOVERNMENT
	PARTNERSHIP		LLC		

Has there been any Change of Name, Ownership, or Location since your last application/renewal?

___ Yes ___ No (If yes, a new application must be submitted)

For Change/Notification Requirements, please refer to Oklahoma Pharmacy Rules, Section 535:25-3-7

M. Disciplinary History:

Please answer each of the following questions **YES (Y) or NO (N)**. For the purpose of the questions below, "applicant" means the Pharmacy listed in Section A above. **All "YES" answers MUST be explained in detail in a separate addendum.** The addendum shall identify the person/entity to whom the "Yes" answer applies and shall include the jurisdiction and all other information requested. Failure to disclose any of the requested information may result in the denial of this application and/or other appropriate action. The addendum form that shall be used to provide this information may be found at: <https://ok.gov/pharmacy/Licensees & Applicants/Forms & Applications/Pharmacies/index.html>

1.	Since the last renewal or within the last 24 months, has the applicant or any of its owners or its pharmacy manager/PIC pled guilty or nolo contendere to or been found guilty of violating any federal or state felony offense statutes or any federal or state misdemeanor offense statutes involving prescription drugs and/or controlled substances? Are any such charges or indictments pending?	Y or N
2.	Since the last renewal or within the last 24 months, has any federal (e.g., FDA, DEA) or state (e.g., OBNDD) regulatory or law enforcement agency found that the applicant or any of its owners or its pharmacy manager/PIC has violated any federal, state, or local laws or foreign laws? Is there any such action pending?	Y or N
3.	Since the last renewal or within the last 24 months, has suspension, revocation or any other sanction been imposed against a license currently or previously held by the applicant or any of its owners or its pharmacy manager/PIC for violating federal or state laws? Has the applicant or any of its owners or its pharmacy manager/PIC surrendered a license?	Y or N
4.	Since the last renewal or within the last 24 months, has the applicant had any application for a license or permit refused or denied by any licensing authority?	Y or N
5.	Since the last renewal or within the last 24 months, has the applicant had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited or restricted?	Y or N

I swear and affirm under penalty of perjury pursuant to Title 21 O.S. 491 and/or discipline by the Board of Pharmacy under the pharmacy laws and rules of the State of Oklahoma that all information I have supplied herein is true and complete.

THIS SIGNATURE MUST BE NOTARIZED:

Printed Name & Title of Responsible Person/Representative

Signature of Responsible Person/Representative

State of _____)

County of _____)

Subscribed and sworn to or affirmed before me this _____ day of _____, 20____.

THE FOLLOWING MUST BE SUBMITTED WITH THIS APPLICATION:

Notary Public

1. Renewal Fee (**ONLINE ONLY**- See Top of Page 1 for Fee Breakdown)
2. All items listed in Section H (**Non-Resident Pharmacies**)
3. Charges & Convictions Addendum (*if applicable*)
4. CDS Inventory taken between May 1 and July 1 (**Resident Pharmacies**)
5. **Current Description of Operations (Non-Resident Pharmacies only)**

PLEASE MAKE SURE THIS APPLICATION IS COMPLETE AND ALL ATTACHMENTS ARE PRESENT BEFORE SUBMISSION. VERIFY SIGNATURES AND NOTARIES. ANY DEFICIENCIES COULD RESULT IN THIS APPLICATION BEING RETURNED. SHOULD THIS HAPPEN, YOU WILL BE SUBJECT TO ANY LATE FEES/REINSTATEMENT FEES ASSESSED. ANY CERTIFICATE NOT RENEWED IS SUBJECT TO CANCELLATION 30 DAYS AFTER EXPIRATION.