****The Commonwealth of Massachusetts

Department of Public Health, Bureau of Health Professions Licensure

Prescription Monitoring Program

250 Washington Street, Boston, MA 02108-4619

Phone: 617-753-7310 Fax: 617-973-0985

**Massachusetts Request for Annual Waiver of Daily Data Submission**

In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Pharmacies that do not dispense Controlled Substances in Schedules II-V, or any additional drugs that the Department has determined must be reported to the PMP, may complete this form to request a waiver of the requirements that pharmacies must report to the PMP. If a pharmacy receiving this waiver nevertheless dispenses from Schedules II-V or any additional drug required for submission to the PMP by the Department, the waiver will not apply to such activity. The pharmacy will be required to report such dispensing to the PMP. Please submit to the Department by July 1st of each year via email to: [mapmp.dph@mass.gov](mailto:mapmp.dph@mass.gov)

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| **Business Type (select one):**  MA Pharmacy  Out of State Pharmacy  VA Pharmacy  Mail Order Pharmacy | | **Please provide all applicable license number(s) for your facility:**  National Provider Identifier (NPI):  Drug Enforcement Administration (DEA):  Massachusetts Board of Pharmacy (MBOP): |
| **Reason for Waiver:** | | |
| **Waiver Status:** Renewal New Request | | |
| **Business Information** | | |
| Business Name:  Business Address: | Facility Name (if applicable):  City:       State:       ZIP: | |
| Business Phone: (     ) -       -       Ext:       Business Website: | | |
| Business Contact Name: | | | |
| Business Contact Phone: (     ) -       -       Ext: | | | |
| Business Email Address: | | | |

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| **Pharmacist In Charge (PIC)** |
| PIC Name: |
| PIC Phone:(     ) -       -       Ext**:** |
| PIC Email Address: |

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| **IT/ Software Vendor (if applicable)** |
| Vendor Name: |
| Vendor Product Name/Version: |
| Primary Contact for Software Vendor: |
| Vendor Phone: (     ) -       -       Ext: |
| Vendor Email Address: |

***I hereby certify that the information on this application is true to the best of my knowledge and that my pharmacy does not dispense***

***any controlled substances that must be reported to the PMP.***

*Requesting Authority:*

|  |  |  |
| --- | --- | --- |
| Name: | Signature: | Date: |

*DPH USE ONLY*

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| Approved by: | Signature: | Date: |

For additional information on pharmacy exemptions please visit: www.mass.gov/dph/dcp/pmp or contact the PMP by telephone: 617-753-7310.