



## SATELLITE PHARMACY SERVICES APPLICATION

**Satellite Pharmacy** - A facility not located at the same location as a Class A or Class C pharmacy at which satellite pharmacy services are provided. A satellite pharmacy may not store bulk drugs and may only store prescription medications that have been previously verified and dispensed by the provider pharmacy. A satellite pharmacy shall be under the continuous, physically present supervision of a pharmacist at all times the satellite pharmacy is open to provide pharmacy services. See Rule [§291.129 Satellite Pharmacy](#), for the complete rules and regulations.

**Satellite pharmacy services** - The provision of pharmacy services, including the storage and delivery of prescription drugs, in an alternate location.

**Provider pharmacy** - A Class A or Class C provider pharmacy may establish a satellite pharmacy in a location that is not at the same location as a Class A or Class C pharmacy. The provider pharmacy and the satellite pharmacy must have:

- (A) the same owner; and
- (B) share a common electronic file or have appropriate technology to allow access to sufficient information necessary or required to process a non-dispensing function.

Type or clearly print (all blanks must be complete – if not applicable, enter N/A)

|   |                                    |                                  |   |                          |
|---|------------------------------------|----------------------------------|---|--------------------------|
| <b>1 Satellite Pharmacy Information</b>                   |                                    |                                  |   |                          |
| _____   |                                    |                                  |   |                          |
| Remote Site Name  |                                    |                                  |   |                          |
| _____   |                                    | _____                            | _____                                     | _____                    |
| Remote Site Street Address:                               |                                    | Ste.                             | City                                      | State Zip                |
| _____   |                                    |                                  | _____                                     |                          |
| Remote Email Address                                      |                                    |                                  | Remote Site Phone Number                  |                          |
| _____   |                                    |                                  | _____                                     |                          |
| If applicable, Federal Controlled Substances Registration |                                    |                                  | Anticipated Date for Commencing Operation |                          |
| _____   |                                    |                                  | _____                                     |                          |
| <b>2 Provider Pharmacy Information</b>                    |                                    |                                  |   |                          |
| _____   |                                    |                                  |   | _____                    |
| Provider Pharmacy Name                                    |                                    |                                  |   | Provider Phy License No. |
| _____   |                                    | _____                            | _____                                     | _____                    |
| Provider Pharmacy Street Address                          |                                    | Ste.                             | City                                      | State Zip                |
| _____   |                                    | _____                            | _____                                     | _____                    |
| <b>3 Type of Provider Pharmacy (check one)</b>            |                                    |                                  |   |                          |
| <input type="checkbox"/> Class A                          | <input type="checkbox"/> Class A-S | <input type="checkbox"/> Class C | <input type="checkbox"/> Class C-S        |                          |
| <b>4 Pharmacist-in-Charge Information</b>                 |                                    |                                  |   |                          |
| _____   |                                    | _____                            |   | _____                    |
| Pharmacist-in-Charge (PIC)                                |                                    | TX PIC License Number            |   | PIC Phone Number         |

Attach copy of the following:

- Copy of the lease agreement or if the location of the satellite pharmacy is owned by the applicant, a notarized statement certifying such location ownership.

**NOTE:** A completed satellite application must be submitted every two years in conjunction with the pharmacy renewal of the provider pharmacy's license.