



Alaska State Board of Pharmacy
Alaska Prescription Drug Monitoring Program
 550 West 7th Avenue, Suite 1500
 Anchorage, AK 99501-3567
 Phone: (907) 269-8404 Fax: (907) 269-6003
 Email: akpdmp@alaska.gov
 Website: www.commerce.alaska.gov/occ/ppha.htm

REQUEST FOR PAPER SUBMISSION OF DATA TO AK PDMP

Instructions:

- Please complete this form in full. Incomplete requests will be returned.
- Requests shall be mailed to the Alaska Prescription Drug Monitoring Program (AK PDMP).
- Please call 907-269-8404 if you have any questions regarding the AK PDMP.
- Requests are granted for one (1) year, at which time pharmacies must reapply.
- The decision of the PDMP Manager to grant or deny the request shall constitute a final agency action unless appealed to the board by submitting a written notice of appeal with the board within 30 days of the notice of denial.

12 AAC 52.870 WAIVER OF ELECTRONIC SUBMISSION REQUIREMENT BY DISPENSER.

Name: _____

Title: _____

Pharmacy or Facility Name: _____

Pharmacy License Number: _____ DEA Number: _____

Pharmacy Address: _____

Phone: _____ Email: _____

I request a waiver from the electronic submission requirement of data to the AK PDMP based on the following.

I represent a pharmacy or a facility (check one):

- that is suffering a hardship created by a natural disaster or other emergency beyond the control of the dispenser and prevents the dispenser from satisfying 12 AAC 52.865(b).
- that is dispensing in a controlled research project approved by an accredited institution of higher education or under the supervision of a governmental agency. Please attach a description of the research project.
- that dispenses less than 10 prescriptions of controlled substances a month.
- that is located in an area where there is no access to the telecommunication services needed to comply with 12 AAC 52.865(b).
- that will suffer financial hardship if required to acquire the technology necessary to comply with 12 AAC 52.865(b).

Additional Comments:

CONTINUED ON REVERSE

- **Initial** _____ I certify that I will submit a Pharmacy Universal Claims Form or alternate form approved by the board if the request is granted for the required reporting of controlled substances.
- **Initial** _____ I certify that I will inform the Program Manager within thirty days if the basis for the request from electronic reporting no longer exists.

I certify that the above information is correct.

SIGN HERE 

Signature

Date

(NOTARY SEAL)

SUBSCRIBED AND SWORN to before me,
 a Notary Public, in and for the State of _____
 this _____ day of _____, 20 _____.

NOTARY 

My Commission Expires: _____