DC PDMP DISPENSER WAIVER FORM

I request an exemption from reporting to the District of Columbia Prescription Drug Monitoring Program (DC PDMP).

I certify that: (CHECK ONE ONLY)

_____ I represent a DC licensed methadone treatment program or substance abuse treatment pharmacy or facility and therefore am exempt from reporting data, as defined in District of Columbia regulation 10301.5(b).

_____ I represent a DC licensed hospital pharmacy or nursing facility pharmacy that distributes controlled substances (schedules II-V, cyclobenzaprine, butalbital, and gabapentin), as defined in District of Columbia regulation 10301.5(c), for inpatient hospital care or inpatient nursing care only.

_____ I represent a pharmacy or facility that dispensing covered substances to inpatients in hospices licensed or certified by the Department, as defined in District of Columbia regulation 10301.5(d)

_____ I represent a pharmacy or a facility that never possesses or dispenses schedules II-V, cyclobenzaprine, butalbital, and gabapentin, as defined in District of Columbia regulation 10302.1(a)(b) prescriptions and request a permanent zero report, as defined in District of Columbia regulation 10304.

_____ I represent a dispensing facility that is experiencing a hardship created by a natural disaster or other emergency beyond the control of the licensee, as defined in District of Columbia regulation 10305.2(a). Please provide description in a separate document:

_____ I represent an ongoing controlled research project or clinical trial approved by a regionally accredited institution of higher education or under the supervision of a governmental agency, as defined in District of Columbia regulation 10305.2(b). Please attach a description of the research project.

Comments: _____

(Please limit to 60 characters, including spaces)

I further certify that if this pharmacy or facility begins to dispense controlled substance (schedules II-V), cyclobenzaprine, butalbital, or gabapentin prescriptions that qualify for reporting under the provisions of District of Columbia regulation 10302.1(a)(b), I will immediately notify the DC PDMP and will commence reporting immediately.

899 North Capitol Street NE | 2nd Fl, Washington, DC 20002 | E doh.pdmp@dc.gov | https://dchealth.dc.gov/pdmp

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DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DC PDMP DISPENSER WAIVER FORM

Facility Name

DC License Number

Facility Street Address

DC Controlled Substance Number

City, State, Zip

DEA Number

NCPDP Number

Representative Name (Printed)

Phone Number

Title

Email address

Signature

Date

Requests and questions should be submitted to the DC PDMP via email or fax. Upon receipt of a complete Waiver, the Program may take up to ten (10) business days to process and respond.

E-mail: doh.pdmp@dc.gov Fax: 202-442-4767

The Program may grant exemptions and waivers on a case-by-case basis, which shall be subject to the terms and conditions stated in the waiver, limited to a specified time period, and subject to being vacated. Licensees must reapply to renew waivers Denial by the Program of a request for a waiver shall be deemed a final Department action. A dispenser whose request for a waiver is denied may seek review of the final Department action in the Superior Court of the District of Columbia within twenty (20) days after receipt of the notice. The review shall be an on the record review of the decision, and not a de novo review.

For Government Use Only

Date Received (mm/dd/yy)	☐ Approved ☐ Denied	Term (mm/dd/yy)	Expiration Date (mm/dd/yy)	Director or Designee Signature	Date of Action (mm/dd/yy)

Reason for denial: _____

(Please limit to 60 characters, including spaces)

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