DONATED PRESCRIPTION DRUG AND MEDICAL SUPPLY REDISPENSING PROGRAM
DONATION RECORD

- Completion of this form meets the requirements of SD Board of Pharmacy: ARSD 20:51:35:05(3) Donated Prescription Drug and Medical Supply Redispensing Program
- Questions about completion of this form may be directed to 605-362-2737.

DONATION INFORMATION

Name – Donor (print or type) Patient name first, then donor name (if donor is not patient). _____

Date Donated _____

Donor Address _____

Donor Phone Number _____

SD Professional License # (if applicable) _____

Name – Participating Pharmacy or Medical Facility Receiving Donation

_____

Name – Medication (legend) or Medical Supply

_____

Medication Strength _____

Expiration Date _____

Quantity Donated _____

NDC _____

Lot Number _____

Original Dispense Date _____

- I attest that the above name medication or medical supply was stored as recommended by the manufacturer and has not been tampered with.
- I understand that I will not be reimbursed or otherwise seek financial compensation from the receiving pharmacy for my donation.
- Further, I understand that the pharmacy will neither reverse the original prescription claim, nor reimburse the third party for the claim upon acceptance of the donation. The participating pharmacy cannot charge recipient or recipients insurance for the drug or medical supply.
- I understand that the drug or medical supply I am donating cannot be returned to me, it will either be re-dispensed to a different patient or destroyed upon expiration.

SIGNATURE-Donor _____

Date Signed _____

Internal Use Only – To be filled out by receiving pharmacist. Does the donation meet eligibility requirements?

Is/does the drug/supply: (all must be checked to accept)

- ☐ Legend drug
- ☐ Non-controlled substance
- ☐ Room temperature stable (non-refrigerated)?
- ☐ In original, unopened, sealed or tamper-evident packaging?
- ☐ Contain lot number & expiration date?
- ☐ Drug does not have a REMs program (i.e. Thalomid or isotretinoin analog)?
- ☐ In good dating (original dispense date must be within previous 9 months and expiration date on package must be greater than 3 months from today's date (unless it can be used prior to 3 months)?

  _____
- ☐ Donation Accepted
- ☐ Rejected – did not meet criteria. Product destroyed or returned.

Pharmacist Signature:_____ Date: _____