

DRUG REPOSITORY PROGRAM DONATION RECORD

- Completion of this form meets the requirements of the variance approved by SD Board of Pharmacy to rule: ARSD 20:51:12:02 Return of Unused Drugs effective 7/1/2019 for donating drugs and supplies.
- Questions about completion of this form may be directed to 605-322-8300.

DONATION INFORMATION

Name – Donor (print or type) Patient name first, then donor name, if donor is not patient.	Date Donated
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Name – Pharmacy or Medical Facility Receiving Donation

Name – Medication 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.
- I understand that the drug or 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
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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)?

- Donation Accepted
- Rejected – did not meet criteria. Product placed into the MedSafe receptacle.

Pharmacist Signature: _____ Date: _____