

After filling out form, print, sign, and mail to: Iowa Board of Pharmacy
400 SW 8th Street, Suite E, Des Moines, Iowa 50309-4688. Deadline for inclusion on
Board's agenda is three weeks prior to Board meeting.

IOWA BOARD OF PHARMACY
Petition for Waiver Variance
(check the appropriate box)

Case No. or State ID No.

Rec'd:

(FOR PHARMACY BOARD USE ONLY)

PLEASE PRINT OR TYPE ALL INFORMATION IN INK

A waiver excuses the petitioner from the requirements of a rule in its entirety or from a part of a rule; a variance does not. Instead, a variance is a modification to the requirements of a rule or a part of a rule. Example: A rule requires the fencing of certain property and further requires that the fence be at least 6 feet in height. A waiver of that rule would excuse the petitioner from the requirement for fencing the property. A variance would require the property be fenced but would allow the petitioner to maintain the current fencing configuration of 5 feet in height (perhaps the fence was constructed prior to the height requirement). When replacement of the current fence becomes necessary as a consequence of normal wear and tear, the variance would terminate and the petitioner would be required to comply with the 6-foot height requirement.

Note: Statutory requirements that have been repeated in administrative rules are not subject to consideration for a waiver or variance.

Is this petition an initial request or is it a request for renewal? Initial Request Request for Renewal
If a request for renewal, explain below why the renewal is necessary.

Petitioner Information (include licensee/registrant name and name of contact person, i.e. pharmacist in charge)

Name: **Thompson & Thompson LTC/Todd Thompson** Phone No.: **319-653-1043**
aka. Victor Drug *(include area code)*
Address: **1010 W. Madison**
City: **Washington** State: **IA** Zip Code: **52353**

Petition Information

1. Chapter Number and Title.

Chapter 9, AUTOMATED MEDICATION DISTRIBUTION SYSTEMS AND TELEPHARMACY SERVICES

2. Rule Number(s) and Title(s).

9.3 (2) Telepharmacy

3. Describe in your own words the essence of each Rule Number(s) and Title(s) that pertains to this petition.

9.11 (2) Waiver from utilization of an AMDS in the process of the Remote Dispensing. Pharmacy will still utilize an independent automated pharmacy system for the practice of telepharmacy, but not the utilization of traditional AMDS or robotic dispensing devices.

4. Describe the specific nature and scope of your petition. In your description, include the anticipated time period (beginning and ending) for which the petition would apply. A waiver or variance may not be requested or granted on a permanent basis; the petition must identify an end date.

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This pharmacy has operated in this capacity for nearly two years with no issues and virtually no errors. It is our understanding the Board is still in the process of development of rules regarding this practice and request this Waiver be extended for another 18 months from this date.

5. Describe the relevant facts and reasons that, in your opinion, justify and provide "clear and convincing evidence" as to why this petition merits consideration for waiver or variance. In your description, explain why the rule(s) poses an undue hardship. If there is a public health, safety and welfare issue associated with this rule(s), or if this rule(s) addresses security or confidentiality issues, also explain how equal protection will be maintained if this petition were granted.

The pharmacy has operated as a telepharmacy for significant time with virtually no errors utilizing the current system, integration of a full blown AMDS or robotic dispensing system is neither beneficial nor feasible at this location. As a smaller aging community the residents have benefited by having more direct access to pharmacy services, pharmacist oversight of OTC medications, and direct access to and communication with a pharmacist in the community, thus creating a generally healthier community.

6. Does anyone else (inside or outside state government) possess knowledge relevant to this petition?

Yes No Do not know

If yes, list their names, addresses and phone numbers below.

7. Would anyone (inside or outside state government) be adversely affected if this petition were granted?

Yes No Do not know

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8. Do you know how the Board of Pharmacy has treated similar situations?

Yes No

If yes, describe below how similar situations were handled.

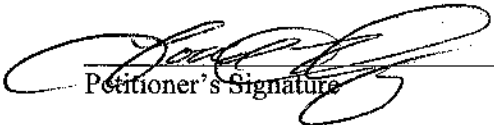
9. Have you had any past interaction with the Board of Pharmacy that might impact or relate to this petition?

Yes No

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Address: **1010 W. Madison**
City: **Washington** State: **IA** Zip Code: **52353**

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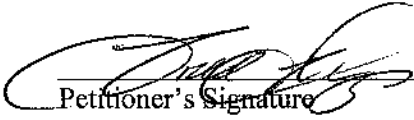
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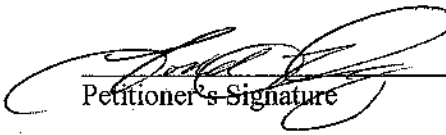
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