Virginia Department of Medical Assistance Services
Unit Dose Request Form

Thank you for your request to be certified as a Unit Dose System Dispenser (**the pharmacy shall dispense not more than a seven-day supply of a drug in a solid, oral dosage form at any one given time.**). Each dose must be packaged individually; Each dose must be labeled identifying the drug and strength; Packaging/labeling must meet the requirement established by the Virginia Board of Pharmacy for unit-dose dispensing; Up to a seven day supply can be dispensed to the facility; A multiple-day dose (e.g., greater than seven days and up to 30-days supply **system** does **not** qualify for unit-dose certification). The facility must be identified as a nursing facility. The unit dose package is then placed in the patient's bin or drawer which is labeled only with the patient's name and location and delivered daily to the nursing home to qualify for unit dose dispensing. Unit-dose dispensing to a home for the aged, adult day care residence, or assisted living facility does **not** qualify for unit-dose certification.

Type or print the information requested below.

Pharmacy Name _____   Pharmacy NPI # _____

Physical Address _____   Telephone #_____

City, State, Zip _____

I.   Be advised this pharmacy provides unit-dose pharmaceutical services to the following listed nursing home facilities:

             Name of Facility   Address

1. _____   _____

2. _____   _____

3. _____   _____

4. _____   _____

5. _____   _____

6. _____   _____

II.   The unit-dose system utilized by this pharmacy is known commercially as _____.

III.   Currently, the following dosage forms are provided in unit-dose packages:

Type	**Yes**	**No**	**Type**	**Yes**	**No**
Capsules and tablets	_____	_____	Suppositories	_____	_____
Oral liquids	_____	_____	Others _____	_____	_____
Others _____	_____	_____	Others _____	_____	_____

IV.   Submitted by: Name   Position   Date

V.   I certify that _____ Pharmacy **agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**

(Signature of Owner or Official)   (Date)

Official Use ONLY: Approved ☐ Denied ☐   Signature: _____ Date:_____