Washington State Department of Health

Medication Donation Form Instructions

For pharmacies participating in the Prescription Drug Donation Program, please make sure that the Medication Donation Form accompanies all donated prescription drugs and supplies submitted by a patient or a patient's representative.

Donor or Representative Information:

- Donor or Representative Name- Name should be printed and legible
- Facility Name- For a Provider(s), Practitioner(s), Medical Facility(s), Wholesaler(s) or Drug Manufacturer(s) only. Name should be printed and legible.
- Address- Home address for Donors and Donor Representatives, Business address for Providers, Practitioners, Medical Facilities, Wholesalers or Drug Manufacturers.
- Phone- Home phone number for Donors and Donor Representatives, Business phone number for Providers, Practitioners, Medical Facilities, Wholesalers or Drug Manufacturers.

Medication Information:

- Drug Name- Print the complete brand or generic name of each prescription drug or supply being donated. Each individual drug must be listed separately. A prescription drug or supply not identifiable from a pharmacy or manufacturer's label or provider container or in the pharmacist's professional judgment cannot be identified will not be accepted for donation.
- Lot Number- If available, provide the exact number as shown on the pharmacy label or container or manufacturer's label or container being donated.
- Expiration Date- If available, provide the actual manufacturer's expiration date as shown on the pharmacy label or container, manufacturer's label or container or individual prescription drug item or supply.
- Source- (Where the prescription drug or supply is obtained from by the donor)
    - For a donor or donor's representative- the source is the name of the pharmacy, provider or practitioner, medical facility or drug manufacturer.
    - For a provider or practitioner- the source is the name of the patient, including their address, a pharmacy, another provider or practitioner, a medical facility, a wholesaler or manufacturer.
    - For a medical facility- the source is the name of the provider or practitioner, a wholesaler or manufacturer
    - For a wholesaler- the source is the name of another wholesaler or manufacturer.
    - For a manufacturer- the source is marked as not applicable.
- Quantity Remaining- Exact quantity for each individual prescription drug and supply being donated. (I.e. tablets, capsules, vials, grams, etc.)
- NDC number or National Drug Code number- If available, provide the exact number, including dashes, as shown on the pharmacy label or container, manufacturer's label or container or individual prescription drug item or supply.
- Drug Strength and Dosage- Provide the strength and dosage form as shown on the pharmacy label or container, manufacturer's label or container on the item or container being donated.

Donor Certification:

- Appropriate donor must select and check off correct box. Signature and date of the individual who has possessed the prescription drug or supply must sign and date the form.

Receiving Pharmacist:

- Pharmacist on-duty at the time the donated prescription drugs and supplies are accepted at the participating pharmacy shall sign and date the medication donation form.

Washington State Department of Health

Pharmacy Quality Assurance Commission
360-236-4700

Medication Donation Form

This form must be submitted to a participating pharmacy by a patient or a patient's representative along with the prescription drugs and supplies that you are donating.

Only drugs that meet the conditions in RCW 69.70.050 will be accepted for donation.

- Controlled substances will not be accepted.
- All prescription drugs donated by a patient or patient's representative must have or contain a time temperature indicator.
- For prescription drugs **with** a Time Temperature Indicator (TTI) donated by a patient or patient's representative - Acceptance of these drugs shall be based on available TTI information and the professional judgment of the receiving pharmacist.
- For prescription drugs **without** a Time Temperature Indicator (TTI) donated by a patient or patient's representative - Acceptance of these drugs shall be based on the professional judgment of the receiving pharmacist.

Donor or Representative Information

Donor or Representative Name	Facility Name (if available)	
Address		Phone (enter 10 digit number)
City	State	Zip Code

Medication Information

Drug Name	Lot Number (if available)	Expiration	Source	Quantity Remaining	NDC# (if available)	Drug Strength and Dosage

Donor Certification

By signing below, I attest that to the best of my knowledge the drug(s) listed above have been properly stored, in accordance with the manufacturer's recommendations, and have never been opened, used, adultered, or misbranded.

☐ Provider or Practitioner ☐ Medical Facility ☐ Wholesaler ☐ Drug Manufacturer

Signature _____ Date _____

Person or Person's Representative Certification

For drugs **with** a Time Temperature Indicator, by signing below, I attest to the best of my knowledge the drug(s) listed above have never been opened, used, adulterated, or misbranded.

Signature _____ Date _____

For drugs **without** a Time Temperature Indicator, by signing below, I attest to the best of my knowledge the drug(s) listed above have never been opened, used, adulterated, or misbranded and the drug(s) have been stored in a manner and location that adheres to the conditions established by the manufacturer.

Signature _____ Date _____

Receiving Pharmacist

Pharmacist Signature _____ Date _____