

# 340B Contract Pharmacy Termination

Department of Health and Human Services, Health Resources and Services Administration, Healthcare Systems Bureau  
 OMB No. 0915-0327; Expiration Date: XX/XX/20XX

## Active Contract for 340B ID - Covered Entity Type

Please review the list of active contract pharmacy arrangements for this entity. If you want to request a contract termination, select the appropriate contract(s), requested termination date(s) and termination reason(s).

**Note:** The covered entity's authorizing official will be notified by email and will have 15 calendar days to approve or reject the proposed contract pharmacy termination(s).

**Termination Date:** The covered entity is responsible for reporting an accurate termination date for each contract pharmacy arrangement. It is expected that 340B activity has ceased or will cease on the termination date requested.

### Active Contracts

Request to Terminate	Pharmacy Name	City	State	Start Date	Requested Termination Date	Termination Reason
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Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0327. Public reporting burden for this collection of information is estimated to average 0.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10C-031, Rockville, Maryland, 20857.

## Active Contract Selected for Termination for 340B ID - Covered Entity Type

**Note: The covered entity's authorizing official will be notified by email and will have 15 calendar days to approve or reject the proposed contract pharmacy termination(s).**

Note: An asterisk (\*) next to a field name denotes a required field.

Pharmacy Name	City	State	Start Date	Requested Termination Date	Termination Reason

### Requestor Details

**\*Name:**

**\*Title:**

**\*Organization:**

**\* Phone:**  (xxx-xxx-xxxx) Ext:

**\*Email:**

**Remarks:**

## Active Contract Selected for Termination for 340B ID - Covered Entity Type

### Contract Termination Request Confirmation

The covered entity's authorizing official will be notified by email and will have 15 calendar days to approve or reject the proposed contract pharmacy termination(s).

Pharmacy Name	City	State	Start Date	Requested Termination Date	Termination Reason

[Continue](#)

**This request has been processed.**

For additional assistance, please contact the 340B Prime Vendor Program at 1-888-347-2787 or by email at **ApexusAnswers@340bvp.com**.

You may also contact OPA at:

Office of Pharmacy Affairs

Mail Stop 8W03A

5600 Fishers Lane

Rockville, MD 20857

Done