Credentialing Information Required

Contract cannot be implemented without first providing the following information and documents:

Copies of the following license(s) (all must not expire within 30 days):

- Pharmacy License
- Pharmacist in Charge (PIC) License
- Full unrestricted full DEA 2-5
- ***Copy of most current store medication inventory***
- Insurance Coverage – minimum $1million occurrence/ $3million annual aggregate
  - ***Certificate of Liability – Must not expire in the next 30 days***

- Delays will occur if contract documents are not completed and/or required credentialing information is not supplied.

Independent Pharmacy Credentialing Application

***Pharmacy is responsible for notifying PBM of any future change(s) to the information provided in this Pharmacy Credentialing Form.**

***Additional Credentialing may be required to dispense specific compound or specialty products.**

Section A: Pharmacy/ Ownership Information

NPI #:_____ **NCPDP #:**_____

(DBA Name): _____

Corporate Name: _____

Street Address:_____ County: _____

City:_____ State:_____ Zip: _____

Phone #:_____ Fax #: _____

State Tax ID:_____ Email Address: _____

Federal Tax ID: _____ Medi-Cal # (CA Only):_____

Medicaid #:_____ Medicare #:_____

Other than the current name listed above, has pharmacy operated under any other trade or business name? ☐ Yes ☐ No
If yes, please provide details and name[s]: _____

Do you have a full un-restricted DEA ☐ Yes ☐ No DEA #:_____ DEA Exp Date: _____

State License #:_____ State License Exp Date: _____

(List all that apply. Include additional pharmacies on a separate sheet of paper)

Pharmacy Owner Name: _____
First Middle Last

NPI #: _____ **NCPDP #:** _____

(DBA Name): _____

Corporate Name: _____

Dates of ownership: _____ to _____ Email Address: _____

Please list any other pharmacies where a current owner or a family member currently owns, in full or part, or previously owned within the past seven (7) years:

_____

(Please include additional pharmacies on a separate attachment).

Does the pharmacy owner control pharmacy operations? ☐ Yes ☐ No

If no, please provide the name of who controls pharmacy operations:_ _____

Has your pharmacy location provided pharmacy services under a different owner and/or NCPDP # in the past seven (7) years?

☐ Yes ☐ No If yes, please provide the previous pharmacy name, NCPDP# and pharmacy owners:_____

_____

Are there any owners of the pharmacy that are licensed physicians/prescribers? ☐ Yes ☐ No

If yes, please fill out the below information and list any other Physicians/Prescribers that is an owner on a separate sheet of paper. For any other Physician\Prescriber, please also include the same information as noted below.

Physician/Prescriber Owner Name: _____
First Middle Last

Prescriber NPI #: _____ **Prescriber DEA#:** _____

Dates of ownership:_____to _____

Please list any other Physician/Prescriber that is an owner on a separate sheet of paper. For any other Physician/Prescriber, please also include the same information as noted above.

Payment Type: Source of Payment ☐ Check ☐ EFT

Mailing Address if Different (This address will also be used as the pharmacy's payment address)
Is the mailing address the same as the store address? ☐Yes ☐No

Address: _____

City: _____ State:_____ Zip: _____

Phone #:_____ Fax #: _____

Wholesaler Information: (List all wholesalers used)
☐ Amerisource Bergen ☐ Cardinal ☐ McKesson ☐ Other_____

Date of Last Full Medication Inventory: _____

**Pharmacy agrees to perform a full medication inventory and log results bi-yearly

Business Types (Check all that apply):

NCPDP Dispenser Class	NCPDP Dispenser Type	
☐ 1-Independent	☐ 1-Retail	☐ 10-State Hospital
☐ 2-Chain	☐ 4-Long-term Care	☐ 11-Institutional
☐ 4-Clinic	☐ 5-Mail Order	☐ 12-MCO Pharmacy
☐ 5-Franchise	☐ 6-IV Infusion	☐ 13-DME
☐ 6-Gov't/Federal	☐ 7-Non-Pharmacy Dispensing	☐ 14-Clinic Pharmacy
☐ 7-Alternate Dispensing Site	☐ 8-Indian Health Services	☐ 15-Speciality Pharmacy
	☐ 9-VA Hospital	☐ 16-Nuclear Pharmacy
		☐ Military Pharmacy

****If NCPDP Dispenser Type 7-Non-Pharmacy Dispensing is selected, additional information is required:**

If Non-Pharmacy Dispensing Type, please list all prescriber(s) NPI in the section below associated with facility

NPI(s): _____

Language Spoken by Staff (Check all that apply):

Does the staff speak English? ☐ Yes ☐ No

Other Languages: ☐ Spanish ☐ French ☐ Russian ☐ Korean ☐ Chinese ☐ Other: _____

Pharmacy Hours:

24- Hour service? ☐ Yes ☐ No

Monday – Friday: _____ AM to _____ PM
Saturday: _____ AM to _____ PM
Sunday: _____ AM to _____ PM

Pharmacy System Information:

Software Vendor(s): _____

List contact name and information for Software Vendor: _____

Does your pharmacy have Internet Access? ☐ Yes ☐ No

Does your pharmacy currently use a third party reconciliation service? ☐ Yes ☐ No If so, who? _____

Does your pharmacy have e-Prescribing capabilities? ☐ Yes ☐ No

Services and Programs (Check all that apply):

Service/Program:	Service/Program:
☐ Compliance Program	☐ Accept Electronic Prescriptions
☐ Medical Literature	☐ Website for Refills
☐ Emergency Service after hours	☐ Medication Adherence Program
☐ Auto Refill Reminder Program	☐ Closed Door Pharmacy
☐ Drug Interaction Monitoring	☐ Drive Thru Service
☐ Blood Pressure Machine	☐ Handicap Accessible
☐ Blood Pressure Screening	☐ Patient Counseling
☐ Health Care Screenings	☐
☐ Delivery Services	Patient Consultation area:
☐ Delivery Fee $_____	☐ Private ☐ Semi Private

☐ Automatic Dispensing Units ☐ Other: _____
☐Controlled Substance Dispensing
☐Compounding
☐

Section B: Pharmacist-in-Charge (PIC) Information

Pharmacist-in-Charge Name: _____
First Middle Last

Home Address: _____

Date of Birth: _____ Pharmacist NPI # (if applicable): _____

License #: _____ State _____ Expiration Date: _____

Are you currently engaged in the illegal use of drugs? ☐Yes ☐No

("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to dispense medication. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

Have you worked at this pharmacy for less than 5 years? ☐ Yes ☐ No

If yes, please provide the name and NCPDP# of the previous pharmacy: _____

Section C: Additional Pharmacy Employees (If needed, please attach additional sheet(s) to list ALL employees)

PHARMACY MANAGER:

Name: _____ Date of Birth (DOB): _____

Licensed Professional: Yes No **If yes**, what

Profession: _____

License #: _____ State Issued: _____

PHARMACIST(S):

Name: _____ Date of Birth (DOB): _____

State License #: _____ State Issued: _____ Expires On: _____

Name: _____ Date of Birth (DOB): _____

State License #:_____ State Issued:_____ Expires On: _____

PHARMACY TECHNICIANS:

Name:_____ Date of Birth (DOB): _____

Certification #:_____ Expires On: _____

Name:_____ Date of Birth (DOB): _____

Certification #:_____ Expires On: _____

Name:_____ Date of Birth (DOB): _____

Certification #:_____ Expires On: _____

Name:_____ Date of Birth (DOB): _____

Certification #:_____ Expires On: _____

Name:_____ Date of Birth (DOB): _____

Certification #:_____ Expires On: _____

☐ Yes ☐ No Does pharmacy use vendor or external staffing agency to source pharmacist and/or technicians? If yes please list company name and phone number: _____

**Pharmacy is responsible to verify the staffing agency understands & completes all required federal and state training including but not limited to; fraud, waste, and abuse, HIPAA, etc.

Initials Here: _____

Section D: Pharmacy Liability Insurance Policy Information (please include copy of coverage)

Carrier: _____ Policy# _____

Agent:_____ Agent Phone #:_____ Agent Fax #: _____

Amount per Occurrence: Aggregate:

(minimum requirement is $1 million)_____ (minimum requirement is $3 million)_____ Expiration Date: _____

Are the store pharmacists covered under this policy? ☐ Yes ☐ No

Pharmacist in Charge:_____ License #:_____ Expiration Date: _____

Pharmacist:_____ License #:_____ Expiration Date: _____

Licensed Tech:_____ License #:_____ Expiration Date: _____

Please list additional names of pharmacists or licensed techs on a separate sheet of paper. If pharmacists are licensed in different states, please list which states.

Delaware, Kentucky, Maine, Michigan, Mississippi, New Hampshire, North Carolina, Oklahoma, Pennsylvania, Tennessee, Vermont, and Wisconsin Pharmacies: Please provide liability claims / malpractice history as applicable for a minimum of the last 5 years.

Section E: Compounding: Does your Pharmacy process compound drug claims ☐ Yes ☐ No (If No, please disregard this section)

Does your pharmacy have a: ☐ Clean Room ☐ Oven ☐ Hood

Is your pharmacy a member of: ☐ PCCA Member ☐ Medisca Member ☐ Freedom Member

Is your pharmacy a: ☐ Sterile, Low and Medium Compounding ☐ Non-Sterile Basic Compounding
☐ Non-Sterile Complex Compounding ☐ Sterile, High Compounding

Please fill out the following information. Non-responses may delay processing your application:

1. Is your pharmacy accredited by the Pharmacy Compounding Accreditation Board (PCAB) ☐ Yes ☐ No

   If Yes, provide the PCAB Accreditation date:_____ Expiration Date: _____

☐ ☐

2. Is your pharmacy a §503A pharmacy? Yes No

3. Is your pharmacy a §503B pharmacy? ☐ Yes ☐ No

4. Does your pharmacy have a dedicated, exclusive area for general, non-sterile compounding that meets current USP<795> standards? ☐ Yes ☐ No

5. Are all bulk, raw, chemical ingredients used by pharmacy in Compounded Drugs purchased from FDA-registered manufacturing facilities? ☐ Yes ☐ No If No, please explain _____

6. Are all bulk, raw, chemical ingredients used by pharmacy in Compounded Drugs approved by the FDA?
☐ Yes ☐ No If No, please explain _____

7. Does pharmacy compound only patient-specific prescriptions written by a prescriber (not batch of non-patient specific medications) or does pharmacy engage in anticipatory compounding? ☐ Yes ☐ No Comments:
_____

8. Does pharmacy perform Sterile Compounding? ☐ Yes ☐ No If Yes, please answer the questions below:

9. Is pharmacy accredited, certified and/or licensed for sterile compounding? ☐ Yes ☐ No

   If Yes, by what organization?_____**(please provide copies).**

10. Does pharmacy have an area for aseptic compounding of sterile preparations that meets current USP <797> standards?
☐ Yes ☐ No

11. Have pharmacy location facilities and Compounded Drugs been independently tested/inspected for sterility?
☐ Yes ☐ No If Yes, please provide copy of the inspection/testing report.

12. Are all sterile compounds prepared in a barrier isolator which has been certified as ISO 5 by an independent contractor?
☐ Yes ☐ No If Yes, please identify the independent contractor: _____

***Additional Credentialing may be required to dispense specific compound products.**

Section F: Long Term Care (LTC) ☐ Yes ☐ No (If No, please disregard this section)

Definition of Long Term Care:
(a)In general. Except as provided in paragraph (b) of this section, when dispensing covered Part D drugs to enrollees who reside in long-term care facilities, a Part D sponsor must—
(1) Require all pharmacies servicing long-term care facilities, as defined in § 423.100 to—
(i) Dispense solid oral doses of brand-name drugs, as defined in § 423.4, to enrollees in such facilities in no greater than 14-day increments at a time;
(ii) Permit the use of uniform dispensing techniques for Part D drugs dispensed to enrollees in long-term care facilities under paragraph (a)(1)(i) of this section as defined by each of the long-term care facilities in which such enrollees reside; and
(2) Collect and report information, in a form and manner specified by CMS, on the dispensing methodology used for each dispensing event described by paragraph (a)(1) of this section, and on the nature and quantity of unused brand and generic drugs, as defined in § 423.4, dispensed by the pharmacy to enrollees residing in a LTC facility. Reporting on unused drugs is waived for Part D sponsors for drugs dispensed by pharmacies that dispense both brand and generic drugs, as defined in § 423.4, in no greater than 7-day increments.
(b)Exclusions. CMS excludes from the requirements under paragraph (a) of this section—
(1) Solid oral doses of antibiotics; or
(2) Solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance (for example, oral contraceptives).
(c)Waivers. CMS waives the requirements under paragraph (a) of this section for pharmacies when they service intermediate care facilities for the mentally retarded (ICFs/IID) and institutes for mental disease (IMDs) as defined in § 435.1010 and for I/T/U pharmacies (as defined in § 423.100).
(d)Applicability date. The applicability date for this section is January 1, 2013. Nothing precludes a Part D sponsor and pharmacy from mutually agreeing to an earlier implementation date.
(e)Copayments. Regardless of the number of incremental dispensing events, the total cost sharing for a Part D drug to which the dispensing requirements under this paragraph (a) apply must be no greater than the total cost sharing that would be imposed for such Part D drug if the requirements under paragraph (a) of this section did not apply.
(f)Unused drugs returned to the pharmacy. The terms and conditions that must be offered by a Part D sponsor under § 423.120(a)(5) must include provisions that address the disposal of drugs that have been dispensed to an enrollee in a long-term care facility but not used and which have been returned to the pharmacy, in accordance with Federal and State regulations, as well as whether return for credit and reuse is authorized where permitted under State law.

Which types of LTC facilities do you service: ☐ Skilled nursing facilities ☐ Assisted Living Facilities

List Facilities: _____

List the name of states that pharmacy is licensed to provide LTC services:

_____

Your pharmacy service: ☐ Medicare members ☐ Non-Medicare Members ☐ Both Medicare and Non-Medicare members

Is your pharmacy contracted for Medicaid ☐ Yes ☐ No If Yes**,** which states: _____

Does your pharmacy belong to a GPO? ☐ Yes ☐ No If Yes, which GPO? _____

Part D LTC Pharmacy Network: Is your pharmacy in compliance with the LTC Pharmacy requirements listed on the Long Term Care Pharmacy Network Exhibit and Compensation Exhibit ☐ Yes ☐ No

Section G: Home Infusion (HI) ☐Yes ☐ No (If No, please disregard this section)

Definition: Home Infusion providers:
(i) Are capable of delivering home-infused drugs in a form that can be administered in a clinically appropriate fashion.
(ii) Are capable of providing infusible Part D drugs for both short-term acute care and long-term chronic care therapies.
(iii) Ensure that the professional services and ancillary supplies necessary for home infusion therapy are in place before dispensing Part D home infusion drugs.
(iv) Provide delivery of home infusion drugs within 24 hours of discharge from an acute care setting, or later if so prescribed.

1. Is your pharmacy accredited with JC (Joint Commission), ACHC and/or another accredited body?
   ☐Yes ☐No Please list your accreditations:

   _____

2. Is your pharmacy Accredited, certified and/or licensed for sterile compounding? ☐ Yes ☐ No

   If Yes, by what organization?_____**(please provide copies).**

If Pharmacy is contracting to participate in the Medicare Part D Home Infusion Network, please fill out the following Medicare Part D Home Infusion (HI) pharmacy requirements information:
Can your pharmacy provide the below services? :

1. Deliver HI drugs in a form that can be easily administered in a clinically appropriate fashion ☐ Yes ☐ No
2. Provide infusible Medicare Part D drugs for both short-term acute care and long-term chronic care therapies ☐ Yes ☐ No
3. Ensure the professional services and ancillary supplies necessary for the provision of HI Therapy are in place before dispensing HI Covered Prescription Services, consistent with the quality assurance requirement for Medicare Part D Sponsors described in 42 CFR 423.153(c) ☐ Yes ☐ No
4. Provide Covered Prescription Services, such as HI drugs within twenty-four (24) hours of discharge from an acute setting, unless the next required dose, as prescribed, is required to be administered later than twenty-four (24) hours after discharge ☐ Yes ☐ No
5. Does pharmacy location listed above have a Clean Room ☐ Yes ☐ No
6. Does pharmacy location listed above have a Hood ☐ Yes ☐ No
7. Does your pharmacy have a Sterile environment to compound infusion therapy drugs ☐ Yes ☐ No
8. Is pharmacy identified with a Home Infusion Taxonomy Code on the NPPES website ☐ Yes ☐ No
9. Please list each state(s) that pharmacy is licensed to provide HI drugs and services:

_____

Section H: Mail Order – Does pharmacy mail/deliver ☐Yes ☐ No (If No, please disregard this section)

Understand if pharmacy mails or delivers via UPS, USPS, Fed-Ex, etc. pharmacy must request a Mail Order Pharmacy Agreement ☐ Yes ☐ No

Is your pharmacy URAC Accredited? ☐ Yes ☐ No If Yes, provide the URAC Accreditation date:_____

Is your pharmacy VIPPS Accredited? ☐ Yes ☐ No If Yes, provide the VIPPS Accreditation date:

_____

Does your pharmacy understand mailing under the retail pharmacy contract is prohibited? ☐Yes ☐ No

Is your pharmacy licensed in each state that it will mail Covered Prescription Services, including compliance with any non-resident pharmacy requirements? ☐ Yes ☐ No

Please list each state(s) that pharmacy mails or intends to mail prescription drug products:

_____

Pharmacy agrees to provide copy(s) of applicable non-resident licensure or registration upon request: ☐ Yes ☐ No

Pharmacy acknowledges, understands and agrees that it is prohibited from mailing covered prescription services under a retail agreement without explicit written authorization from PBM: ☐ Yes ☐ No

Section I: Specialty ☐Yes ☐ No (If No, please disregard this section)

Is your pharmacy URAC Accredited? ☐ Yes ☐ No If Yes, provide the URAC Accreditation date:_____

Is your pharmacy VIPPS Accredited? ☐ Yes ☐ No If Yes, provide the VIPPS Accreditation date:_____

Is your pharmacy licensed in each state that it is mailing Covered Prescription Services, including compliance with any non-resident pharmacy requirements? ☐ Yes ☐ No

Please list each state(s) that pharmacy mails or intends to mail prescription drug products:

_____

Pharmacy agrees to provide copy(s) of applicable non-resident licensure or registration upon request: ☐ Yes ☐ No

***Additional Credentialing may be required to dispense specific specialty products.**

Section J: 340(B) Certification

Company hereby certifies that as of the Effective Date of this Application hereof that Company:

☐ _____*[PLEASE INITIAL]* **is** a provider for and is eligible to distribute Drug Products under the Public Health Service Act, Section 340(B).

☐ - OR -
_____*[PLEASE INITIAL]* **is not** a provider for and is not eligible to distribute Drug Products under the Public Health Service Act, Section 340(B).

If Company **is not** eligible to distribute Drug Products under the Public Health Service Act, Section 340(B), to the extent that Company, during the term or any renewal term of this Agreement, becomes eligible to distribute Drug Products under the Public Health Service Act, Section 340(B) program, Company shall immediately provide Administrator with written notice of such eligibility. The parties acknowledge and agree that Administrator shall be entitled to modify the rates, fees and other reimbursements offered to Company hereunder, upon Administrator's written notice to Company, to the extent that Company becomes eligible to distribute Drug Products under the Public Health Service Act, Section 340(B) program. Failure of Company to notify Administrator of its 340(B) eligibility as stated above shall constitute a material breach of this Agreement.

☐Yes ☐ No If 340B Covered Entity, do you segregate your inventory?

Section K: Marketing and Prescriber Detailing Operations

Please check all that apply**:**

1. Does your pharmacy offer direct or indirect compensation to physicians or other prescribers for referrals to prescribe particular Compounded Drugs or to direct prescriptions to particular pharmacies? ☐ Yes ☐ No

2. Does your pharmacy market or promote your drug services at trade shows, to payers, physicians or other prescribers?
   ☐ Yes ☐ No If yes, please provide sample(s)

3. Does your pharmacy have any partnerships with prescribing physicians? ☐ Yes ☐ No If yes, please describe and provide sample copy of any materials?

4. Does your pharmacy market physicians or other prescribers to promote your pharmacy's Compounded Drug services, or any specific compound preparation or prescription? . ☐ Yes ☐ No

   If yes, describe the employment/contractual relationship between the pharmacy and the detailers (check all that apply):

   ☐ 1099 Contractors (Count:_____) ☐ Employees (Count:_____)
   ☐ Mixed ☐ Sub-contractor(s) (If so, Name:_____)

5. Does your pharmacy have a Code of Business Conduct/Ethics that your sales and detailers need to adhere to?
   ☐ Yes ☐ No If yes, please provide a copy of your organizations Code of Business Conduct/Ethics.

6. Does your pharmacy have a website? Yes No If Yes, please provide the website address:

   _____

7. Does your pharmacy market delivery of medications? Yes No If Yes, explain:

Section L: General Questions

(If providing explanation, please attach each additional pages/documents as needed)

☐Yes ☐No 1) Is your pharmacy currently affiliated with another chain code through NCPDP?
If yes, name of affiliation _____

☐Yes ☐No 2) Is your pharmacy certified as: (Check all that apply)
☐Women Business Enterprise ☐Minority Business Enterprise ☐Small Business Enterprise
If yes, please provide copy of certification

☐Yes ☐No 3) Is your pharmacy currently participating in a francise? If yes, name of franchise:
_____

☐Yes ☐No 4) Does your pharmacy mail prescriptions? If yes, explain: _____

☐Yes ☐No 5) Is your pharmacy currently open for business? If no, expected opening date: _____

☐Yes ☐No 6) Is the pharmacy able to transmit claims electronically in the required format?

☐Yes ☐No 7) Is the pharmacy able to participate with the on-line Drug Utilization Review?

☐Yes ☐No 8) Is the pharmacy able to participate in external audits and grievance procedures?

☐Yes ☐No 9) Is your pharmacy currently in good standing with the State Board of Pharmacy and/or other Federal or State licensing authorities? If No, please provide a letter of explanation and include the dates.

☐Yes ☐No 10) Has your pharmacy or Pharmacist-in-Charge (PIC) ever been denied a license or permit or had its license or permit suspended, revoked, or been fined or had other disciplinary action by the State Board of Pharmacy or other federal or state licensing or regulatory authorities? If yes, please provide a letter of explanation and include the dates.

☐Yes ☐No 11) Under current ownership, has this pharmacy, or any of its principals, ever filed for bankruptcy or reorganization?

☐Yes ☐No 12) Will the pharmacy maintain patient profiles, prescription, and signature logs as required by applicable State, Federal and U.S. territorial laws, and advise members that their signature acknowledges their receipt of prescriptions and allow release of any and all claim information?

☐Yes ☐No 13) Has the pharmacy or any of its present owners, officers, or employees ever been convicted of any state or federal law convictions? If yes, please explain: _____

☐Yes ☐No 14) Are you or pharmacy under any restriction of practice imposed by any State Board of Pharmacy? If yes, please explain: _____

☐Yes ☐No 15) Does the pharmacy comply with all State/Federal/U.S. territorial regulations, including CMS rules and regulations

☐Yes ☐No 16) Do you have a written policy to actively review business operations and finance to minimize potential fraud waste and abuse? If no, please explain: _____

☐Yes ☐No 17) Is the pharmacy located in a rural area?

☐Yes ☐No 18) Is the pharmacy open a minimum 5 days per week / 8 hours per day?

☐Yes ☐No 19) Does your pharmacy have any offshore activity that involves the use of PHI? (i.e. Call Center, claims reconciliation, etc.) If yes, please explain: _____

☐Yes ☐No 20) Does your pharmacy comply with the regulations to protect PHI?
What is your current policy for destruction of PHI? _____
If an outside vendor is used, provide company name: _____

☐Yes ☐No 21) Has pharmacy previously been suspended, terminated or excluded from Administrator's network in the past five (5) years for failing to adhere to the terms of this Agreement or any prior or subsequent agreements with Administrator or Administrator's successor?

☐Yes ☐No 22) Has pharmacy previously been suspended, terminated or excluded from any Pharmacy Benefit Management (PBM) network in the past five (5) years for cause? If yes, please explain:
_____

☐Yes ☐No 23) Within the past five years, has any pharmacist who is currently employed in your pharmacy been cited by any State Board of Pharmacy for violations, leading to the suspension or revocation of a pharmacy license? If yes, please explain: _____

☐Yes ☐No 24) Has the pharmacy or any currently employed pharmacist, ever been under investigation or sanctioned by Medicare or Medicaid? If yes, please explain: _____

☐Yes ☐No 25) Does any pharmacist employed in your pharmacy have a restricted license to practice pharmacy in the state where your facility is located? If yes, please explain: _____

☐Yes ☐No 26) Does your pharmacy regularly monitor and provide oversight of the operations at each of its Pharmacies and their pharmacies and maintains a credentialing program for itself and each of its Pharmacies?

☐Yes ☐No 27) Pharmacy has and will continue to provide the necessary training to its staff to comply with all State and Federal programs?

☐Yes ☐No 28) Is the pharmacy able to comply OBRA 90 rules and guidelines?

☐Yes ☐No 29) Does your pharmacy understand waiving member copays is against the pharmacy contract and/or pharmacy manual?

☐Yes ☐No 30) Does your pharmacy timely acquire and remediate medication situations related to a manufacture recall?

☐Yes ☐No 31) Does your pharmacy have a policy to destroy and/or return expired medications on the shelf?

☐Yes ☐No 32) Is there an area in the store designated for individualized patient evaluation and counseling allowing for reasonable privacy? If no, please explain: _____

☐Yes ☐No 33) Does your pharmacy have a designated patient waiting area with seating? If no, please explain:
_____

☐Yes ☐No 34) Does your pharmacy have a designated parking area allowing easy accessibility for your patients? If no, please explain: _____

☐Yes ☐No 35) Does your pharmacy have professional liability and general liability insurance coverage? If no, please explain:
_____

☐Yes ☐No 36) To the best of Company's knowledge, has or will Company, any Pharmacy location (including pharmacies currently in the network and new pharmacies included in the network after execution of this Agreement), pharmacist, subcontractor, or other personnel furnishing (or which will furnish) Covered Prescription Services to Members, been or be (i) listed as debarred, excluded, or otherwise ineligible for participation in federal health care programs or (ii) convicted of a criminal felony (for North Carolina, Tennessee and Vermont pharmacies, please include misdemeanor convictions)?

If yes, please explain: _____

Please Indicate: What is the most recent date your pharmacy was inspected by any State Board of Pharmacy?

_____Month_____Year

Section M: MEDICARE

Conflict of Interest

The below initials confirm that the undersigned has policies and procedures in place to ensure that ALL staff responsible for the administration or delivery of Part D services has signed a conflict of interest statement, certification, or attestation at the time of hire, and annually thereafter throughout the employment tenure.

Initials Here: _____

OIG and GSA Certification

The below initials confirm that the undersigned has policies and procedures in place to review the Office of the Inspector General (OIG) and General Services Administration (GSA) exclusions material at the time of hire, and monthly thereafter throughout the employment tenure to ensure that ALL staff is not currently excluded from any Federal health care programs. Should a staff member be identified on the list(s), the staff member will be immediately removed from any and all work relating to a Federal health care program.

Initials Here: _____

The undersigned hereby authorizes Kansas MCOs and designated agents to review any and all records that it reasonably believes necessary for credentialing purposes.

Signature of Authorized Pharmacy Representative.

I certify, represent and warrant that any and all information provided to each of the items related to this credentialing form and in connection with the credentialing process, is true, accurate and complete and it has not failed to state any facts or provide any documents that may be material in connection with its credentialing process. Failure to provide true, accurate, and complete information in this credentialing application may result in sanctions, up to and including denial to participate and/or termination from all networks.

Signature _____ Date: _____

Print Name: _____