



PARTICIPATING PHARMACY AGREEMENT

THIS PARTICIPATING PHARMACY AGREEMENT (“Agreement”), dated as of __ __, __ is between Pharmacy Providers of the Southeast, LLC, dba, PharmAvail Benefit Management having its address at 4469 Lemon St., Acworth, Georgia 30101. Attention: Pharmacy Network Management Fax: (678) 236-0404 and the pharmacies whose name and address is set forth below (“Pharmacy”):

Pharmacy “DBA” Name: _____

Location Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone: _____

NABP# _____ Federal Tax I.D.# _____

(Attach list if multiple NABP#s)

The parties agree as follows:

1. Responsibilities of Pharmacy. Pharmacy shall dispense prescription(s) to members covered under prescription benefits plans (“Plans”) administered by various plan sponsors or their administrators (“Payors”). Such prescriptions shall be dispensed in accordance with the information communicated by PharmAvail Benefit Management to Pharmacy, applicable state and federal law, and applicable pharmacy practice standards, including all counseling and DUR requirements. Pharmacy shall at all times maintain all applicable licenses and permits, and shall provide evidence of the same to PharmAvail Benefit Management upon request. Pharmacy shall comply with accreditation standards as reasonably required by PharmAvail Benefit Management or Payors. Pharmacy agrees to always collect the applicable copayment as adjudicated by PharmAvail Benefit Management and to never discount or waive such copayment or to collect a greater amount. Pharmacy agrees to provide services to covered members of Plans with a degree of care, skill and attention at least as high as that provided to the general public and as required by applicable state pharmacy regulations. Participating pharmacies should exercise sound professional judgment in their drug dispensing practices. Pharmacy shall dispense the quantity of medication as prescribed, not to exceed the plan maximum benefit. Should Pharmacy require the use of an intermediary, such as MedE America or NDC, to transmit to PharmAvail Benefit Management, Pharmacy shall be responsible for any applicable fees. Pharmacy shall adjudicate prescriptions through PharmAvail Benefit Management utilizing NCPDP version

3.2 or higher. Pharmacy is responsible for maintaining all hardware and software necessary to support the prevailing pharmacy practice and NCPDP approved transmission standards. Pharmacy shall maintain a signature log at each location listing the plan name, Rx number, and the date of receipt of the prescription by the patient or the patient's designee/ agent/ representative. Pharmacy shall require the signature of the patient or the patient's representative on a signature log to guarantee the prescription(s) were received.

2. **Review of Records/ Auditing.** Pharmacy shall maintain all prescription records as required by applicable state and federal law. During business hours and upon reasonable notice, Pharmacy shall provide PharmAvail Benefits LLC with access to review and copy all prescription records, patient medication profiles, billing records and signature records relating to services provided pursuant to this Agreement, as well as insurance, licensure and accreditation records and other business records as reasonably required to confirm compliance with Pharmacy's obligations under this Agreement. If an audit shall disclose that PharmAvail Benefit Management overpaid Pharmacy with respect to any claim which Pharmacy has submitted to PharmAvail Benefit Management for payment, such overpayment as determined by extrapolation, using standard and accepted accounting statistical methodologies, shall be offset against future claims payment causing Pharmacy's future payments to be debited by the calculated recovery amount, if Pharmacy does not remit the requested amount within fifteen (15) days of such a request. The terms of this Section shall survive the termination of this Agreement for any reason.
3. **Eligibility and Coverage.** Claim adjudication, drug utilization review and other edits shall be performed through electronic linkage to PharmAvail Benefit Management. Pharmacy shall access such electronic linkage with PharmAvail Benefit Management for each prescription dispensed. Verification of eligibility, drug coverage and other applicable edits to Pharmacy via the electronic linkage constitutes authorization for Pharmacy to service the Plan member. PharmAvail Benefit Management is not responsible for transmission errors of any kind.
Note: PharmAvail Benefit Management utilizes NCPDP standard ID card format(s) exclusively as a service to network provider, and to improve Pharmacy's ease of servicing the pharmaceutical needs of PharmAvail Benefit Management members. The terms of this Section shall survive the termination of this Agreement for any reason.
4. **Payment.** Pharmacy is entitled to reimbursement for each prescription dispensed to a Plan member at the lower of: (a) the amount applicable to a given Plan or (b) Pharmacy's usual and customary price (i.e., Pharmacy's cash price to the general public at the time of dispensing inclusive of all coupons, discounts, and other deductions), provided that Pharmacy has verified the requisite eligibility and coverage authorization and that Pharmacy has complied with all other applicable Plan design features as defined in the Plan description. Pharmacy agrees to submit claims for payment to PharmAvail Benefit Management not later than thirty (30) days after the date of service. Pharmacy agrees to an administrative transactional fee withhold of \$.25 per transmission. These withholds are utilized for funding of generic incentives, preferred drug, and disease state management programs payable to network pharmacies. Any dispute as to payment must be brought to PharmAvail Benefit Management attention within sixty (60) days after Pharmacy receives the disputed payment from PharmAvail Benefit Management. Any such dispute shall be governed by PharmAvail Benefit Management's grievance policy as then in effect. Payment shall be made at least monthly by PharmAvail Benefit Management. In the event that the prescription is not picked up within two (2) weeks of transmission, Pharmacy shall make a claim to reverse the prescription and if payment has been made to Pharmacy, PharmAvail Benefit Management shall be entitled to reimbursement. PharmAvail Benefit Management may offset any amounts owing to PharmAvail Benefit Management against amounts to be paid to Pharmacy. The terms of this Section shall survive the termination of this Agreement for any reason.
5. **Copayments/ Deductibles.** Pharmacy shall collect the amount of applicable copayment or

deductible from eligible PharmAvail Benefit Management members and accept as payment in full for pharmacy services such amounts as are payable by PharmAvail Benefit Management for such eligible members. In no event, including but not limited to non-profit by PharmAvail Benefit Management, shall Pharmacy bill, charge, collect, or seek recourse against any eligible member for pharmacy services subject to reimbursement by PharmAvail Benefit Management, without prior written consent from PharmAvail Benefit Management. Pharmacy may collect from eligible members other charges for services that are not covered by the PharmAvail plan.

6. Indemnification/Insurance. Each party shall indemnify and hold harmless the other party, its directors, officers, employees and agents against all claims, liabilities, losses, damages, costs or expenses of any kind which arise as a result of the negligence or misconduct of the indemnifying party in performing any services under this Agreement. Each party shall maintain professional liability and general liability insurance in adequate amounts to cover their risks under this Agreement, but not less than \$1,000,000 in professional liability coverage. Each party shall provide a current certificate of coverage to the other party upon request. *Exception: Nothing in this section suggests either party indemnifies the other against any claims, liabilities, losses, damages, cost or expenses of any kind which arise from violation of HIPAA regulations or material breach of confidentiality under various and applicable state laws or pharmacy regulations. Patient names will not be a required data element for PharmAvail Benefit Management claims submission except where required by state/federal law or state worker's compensation regulations.* The terms of this Section shall survive the termination of this Agreement for any reason.
7. Term and Termination. The initial term of this Agreement shall be twelve (12) months from the Effective Date. Thereafter, the term shall be automatically renewed annually for successive additional twelve (12) month periods, subject to the right of either party to terminate this Agreement upon at least 90 days prior written notice; provided, however that PharmAvail Benefit Management shall also have the ability to terminate this Agreement effective upon receipt of notice by Pharmacy, for breach of this Agreement or for other good cause.
8. Advertising and Promotion. Pharmacy agrees that it shall display any signage provided by PharmAvail Benefit Management that helps identify pharmacy as a participating network pharmacy (i.e. a window decal). Pharmacy may advertise that it is a member of PharmAvail Benefit Management's network of retail pharmacies. Pharmacy shall cease any and all such usage immediately upon termination of this Agreement.
9. Miscellaneous Provisions.
 - A. This Agreement supersedes all prior or contemporaneous understandings or contracts, and constitutes the entire agreement existing between the parties regarding the subject matter of this Agreement. No waiver or discharge of any breach of this Agreement shall be effective unless it is in writing signed by the other party. Any waiver of any breach of any provision of this Agreement shall not be a waiver of any subsequent breach of any provision of this Agreement. This Agreement may not be modified except in writing signed by both parties.
 - B. Neither party shall be liable for failure or delay of performance arising from an act of God or other events beyond control of a party, such as an act of a regulatory agency, fire, flood, explosion, strike, labor stoppage, computer malfunction or act of war, terror or rebellion.
 - C. Each party shall comply with the provisions of all applicable federal, state and local laws and regulations in connection with the subject matter of this Agreement. Neither party shall make payments or perform any services under this Agreement that would be

prohibited by law. No part of this Agreement shall be construed to induce or encourage the referral of patients, and no payment made pursuant to this Agreement or any other agreement between PharmAvail Benefit Management and Pharmacy shall be construed to induce the purchase, lease, order or arrangement for the furnishing of healthcare products or services.

- D. All notices provided for in this Agreement shall be in writing and shall be sent by registered or certified mail or by overnight courier addressed to the other party at the address listed above.
- E. This Agreement and its interpretation shall be governed by the internal laws of the State of Georgia.

IN WITNESS WHEREOF, authorized representatives of the parties have signed this Agreement.

PHARMAVAIL BENEFIT MANAGEMENT

_____	(Name of Pharmacy/ Pharmacy Group)
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

Please sign and return to PharmAvail Benefit Management. If multiple stores, please attach additional listing with information for all categories listed in the first paragraph of this Agreement. PharmAvail Benefit Management will subsequently return an executed copy of Agreement to Pharmacy/ Pharmacy Group.

**PharmAvail Benefit Management
Pharmacy Credentialing Application**

General Information

Pharmacy Name: _____

Legal Name (if different than Pharmacy Name): _____

NCPDP #: _____

Location Address: _____

City: _____ State: _____ Zip: _____

Correspondence Mailing Address (if different than above): _____

City: _____ State: _____ Zip: _____

Payment Mailing Address (if different than above): _____

City: _____ State: _____ Zip: _____

Type of Pharmacy Practice (choose as many as apply):

- Retail (open to the public) Clinic/ Hospital Outpatient (closed to the public)
 Hospital Inpatient Long Term Care Mail Service
 Closed Facility Other (describe: _____)

Type of Pharmacy Location (choose ONE only):

- All claims submitted under this single NCPDP #
 Co-located with another pharmacy operation submitting claims under a different NCPDP #

Type of Facility (choose ONE only)

- Pharmacy is in the main business
 Grocery-type store where the Pharmacy is one of many departments
 Department-type store where the Pharmacy is one of many departments
 Other (describe: _____)

Type of Pharmacy Ownership (choose ONE only)

- Independently Owned and Operated (single or multiple locations)
 Chain Owned and Operated
 Independently Owned Franchisee of _____
 Other (describe: _____)

Type of Contracting Affiliation (choose ONE only)

- Pharmacy retains the exclusive rights to contract with 3rd Party Processors such as PharmAvail Benefit Management
 Pharmacy shares its right to contract with 3rd Party processors with the _____ organization
 Pharmacy has assigned its right to contract with 3rd Party processors to the _____ organization

Federal Tax ID # _____ Pharmacy DEA # _____

State Pharmacy Permit # _____

I. Patient Services

1. Hours of Pharmacy Operation:

- a. M-F _____ Sat _____ Sun. _____
- b. 24 hours per day _____ days a week.
- c. Available for after hour emergency calls. Yes/No__

2. Services Provided

Descriptions

- a. Patient counseling? Y or N
- b. Separate counseling area? Y or N
- c. Written literature about prescription? Y or N
- d. Patient reference /resource center? Y or N
- e. Compounding capability? Y or N
- f. Durable medical equipment? Y or N
- g. Delivery service? Y or N
 - 1. Separate charge? Y or N
- h. Handicap access? Y or N
- i. Drive-up window? Y or N
- j. Brown Bag review? Y or N
- k. Blood pressure monitoring? Y or N
- l. In-House Glucose Screening program? Y or N
- m. Other In-House Screening program(s) Y or N
(please list) _____
- n. Hospice Care/ Pain Management Y or N
- o. Credentialed pharmacist in DSM Y or N
(please list disease/ condition and credentialing
body) _____
- p. Available to deliver DSM for additional
payment? Y or N
- q. Vaccinations/ Immunizations Administration
(i.e. flu shots) Y or N

II. Pharmacy Systems

1. Capabilities

- a. "On-line" electronic adjudication? Y or N
- b. Compliance with NCPDP V 3.2? Y or N
- c. Acceptance of on-line DUR messages? Y or N
- d. Generate Patient Profiles? Y or N
- e. Acceptance of Point of Prescribing (POP)
messages? Y or N

III. Pharmacy Operations

1. Does your pharmacy:

- a. Maintain a patient signature log? Y or N
- b. Maintain a policy and procedure manual? Y or N
- c. Provide continuing pharmacist education? Y or N
- d. Have established complaint resolution procedures? Y or N
- e. Have prescription error procedures? Y or N
- f. Have out of stock procedures? Y or N
- g. Have emergency supply procedures? Y or N
- h. Promote generic substitution? Y or N
- i. Routinely stock legal narcotics Y or N

2. Has your Pharmacy:

- a. Had any claims, settlements or judgments against it in the last 10 years? Y or N
- b. Ever filed for bankruptcy, receivership or reorganization? Y or N
- c. Maintained professional and general liability insurance with coverage of not less than \$1,000,000 per occurrence and \$1,000,000 in aggregate for death and personal injury? Y or N
- d. Kept in good standing with all state and federal licensing agencies? Y or N

3. Statistics (Optional)

- a. Generic substitution rate as a percentage of total prescriptions _____%
- b. Percent of annual claim volume processed “ on-line”. _____%

Acknowledgment:

The undersigned hereby acknowledges that the information provided in this document is to the best of his/her knowledge accurate and complete. The undersigned further understands that intentional submission of false or misleading information or the withholding of relevant information is grounds for termination by PharmAvail Benefit Management. The undersigned hereby agrees to notify PharmAvail Benefit Management of any changes in the above information.

Name of Pharmacy

Signature

Printed Name and Title

Date

PharmAvail Benefit Management
***Exclusive HospiCare Rx (Hospice) Network**

Brand Reimbursement AWP – 14% + \$2.00
Generic Reimbursement MAC + \$2.00

Return to:
PharmAvail Benefit Management
4469 Lemon St.
Acworth, GA 30101
Fax: (678) 236-0404

____ Yes, I will be a Provider for the PharmAvail Benefit Management Exclusive “HospiCare Rx” Network. I understand that by signing and returning this form to PharmAvail Benefit Management, the pharmacy (ies) listed below will be added to the PharmAvail Benefit Management Exclusive Network at the parameters PharmAvail Benefit Management has stated above.

Please verify the information below. If pharmacy chain, please attach current store listing.

Pharmacy Name: _____

NABP Number or NCPDP Chain Code: _____

Location or Corporate Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Authorizing Person (Print): _____ (sign): _____

Date: _____

***Exclusive Network** limited to 60% - 70% of available pharmacies within ten miles of member’s zip code, unless initial enrollment (Feb 15, 2002- March 15, 2002) exceeds the above listed threshold. Affiliated groups or chains are allowed to add new pharmacies under their agreement.

If you have further questions, or need further explanation, please call our Pharmacy Services Help Desk at (800) 933-3734.

**PharmAvail Benefit Management
Hospicare Rx Exclusive Network**

**Brand Reimbursement AWP – 14% + \$2.00
Generic Reimbursement MAC + \$2.00**

Return to:

PharmAvail Benefit Management
4469 Lemon Street
Acworth, GA 30101
Fax: (678) 236-0404

____ Yes, I will be a Provider for the PharmAvail Benefit Management’s Exclusive Hospicare Rx Network. I understand that by signing and returning this form to PharmAvail Benefit Management, the pharmacy (ies) listed below will be added to the PharmAvail Benefit Exclusive Hospicare Rx Network at the parameters PharmAvail Benefit Management has stated above.

Please verify the information below. If pharmacy chain, please attach current store listing.

Pharmacy Name: _____

NABP Number or NCPDP Chain Code: _____

Location or Corporate Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Authorizing Person
(Print): _____ (sign): _____ (date): _____

If you have further questions, or need further explanation, please call our Pharmacy Services Help Desk at (800) 933-3734.