GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

SPECIALTY PHARMACY NETWORK APPLICATION

MENTAL HEALTH AND SPECIALTY SERVICES

Date: _____/_____/_____

DC MEDICAID PROVIDER ID: _____ **NPI:** _____

PHARMACY NAME: _____

BUSINESS NAME (IF DIFFERENT FROM PHARMACY NAME): _____

PHARMACY PHYSICAL ADDRESS: _____

CITY, STATE ZIP: _____

PHARMACY PHONE #: (_____)_____ **PHARMACY FAX #:** (_____)_____

PHARMACY EMAIL ADDRESS: _____

PHARMACIST IN CHARGE (PIC): _____

KEY CONTACT PERSON (IF DIFFERENT FROM PIC: _____

PHONE #: (_____)_____ **EMAIL ADDRESS:** _____

OFFICE/BILLING ADDRESS (IF DIFFERENT FROM PHARMACY ADDRESS)

_____

CITY, STATE ZIP: _____

Answer the following questions below. Use additional pages for answers, if necessary.

1. Are you currently an active DC Medicaid Provider? _____Yes _____No
2. Are you able to receive original copies of prescriptions from a prescriber by (Mark all that apply):

   a) Paper:_____b) Fax:_____c) e-script_____
3. Does your pharmacy have the ability to **directly** ship medications to the provider's office with special handling procedures, such as cold or refrigerated requirements? _____Yes_____No

   Please provide a brief description of your shipping and/or special handling procedures below.

   _____

   _____

   _____

   _____

   _____

4. Are you currently adjudicating pharmacy claims through the point-of-sale (POS) processing system compatible with the current NCPDP guidelines? _____Yes _____No

5. Do you understand and certify that the selected injectable antipsychotic medications dispensed under this program are **not to be released directly to the Medicaid beneficiary** but must be **delivered or shipped directly to the prescriber's office or clinic address** for administration by the prescriber. These are physician administered medications requiring special handling and reconstitution, chain of custody and/or temperature control documentation.
   _____Yes _____No

6. Per provider manual section 7.1 "Other injectable medications may be added to the Specialty Pharmacy Network to improve patient adherence." Do you understand and certify that the selected injectable medications dispensed under this program are **not to be released directly to the Medicaid beneficiary** but must be **delivered or shipped directly to the prescriber's office or clinic address** for administration by the prescriber. These are physician administered medications requiring special handling and reconstitution, chain of custody and/or temperature control documentation.
   _____Yes No

7. Do you understand and acknowledge that documentation of all signature logs and/or delivery manifests for these medications will be retained and made available for inspection and audit by the Department of Health Care Finance Program Integrity Unit upon request?

   _____Yes _____No

I hereby attest to the accuracy of the responses given above.

_____ _____
Printed Name of Pharmacist in Charge Title

_____ _____
Signature Date

If you are interested in participating in the Mental Health specialty network, please read, complete and sign the enclosed application and submit to **the DHCF Clinician, Pharmacy and Acute Provider Services Program via fax at 202-722-5685** for review.

If you have any questions or would like more information regarding this program, please contact one the individuals listed below:

- Charlene Fairfax, RPh, Senior Pharmacist, 202-442-907charlene.fairfax@dc.gov
- Gidey Amare, PharmD, MS, Pharmacist, at 202-442-5956 or gidey.amare@dc.gov
- Tayiana Reed, PharmD, MS, Pharmacist at 202-478-1415 or tayiana.reed1@dc.gov

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For Office Use Only

Do Not Write in the Box Below

Application Received _____ Application Reviewed _____

Application meets requirements Y/N Application Approved for Specialty Network Y/N

If yes, date provider will be active in RC Network _____

If no, date RTP letter sent _____

Application Completed by _____

PBM Manager _____ Date _____