ADDENDUM M

USE OF OUTSIDE PHARMACY

Our community strives to offer medication services in a manner that promotes health and welfare, always keeping our residents' best interest in mind. Although we offer the convenience of pharmacy services complementing our same philosophies, we understand that some residents may choose to purchase their medications from an outside vendor. Keeping this in mind, we will support this choice for a nominal processing fee as long as the designated pharmacy can meet the regulations under which this service must be provided. The regulatory guidelines and processing fee are outlined below:

1. Medications shall be dispensed only pursuant to orders in the resident’s medical records, as entered, by a physician or other practitioner licensed to prescribe in the state.

2. Medication shall be dispensed only pursuant to medication orders, transmitted to the pharmacy, by a licensed person who is an employee of the community, using an approved form.

3. Medications shall be shipped directly from the pharmacy of choice to the community’s medication room. Shipment may be conveyed by:
   a. A pharmacist
   b. An independent agent of the pharmacist or pharmacy
   c. Independent delivery
   d. Parcel delivery of U.S. Mail
   e. A physician or other practitioner licensed to prescribe

4. The outside pharmacy shall furnish a copy of the resident’s medication profile in a format approved by Ageia, to the community’s pharmacy consultant, on a monthly basis.

5. All medication, whether prescription or non-prescription, shall be properly labeled in accordance with the policies of the community.

6. The medication, whether prescribed or over-the-counter, shall be delivered in the unit-of-use system used by the community or arrangements made to convert them to this system.

7. The outside pharmacy shall provide the community with a telephone number that may be reached 24 hours a day for information or emergency service and delivery of medications. Emergency medication deliveries must be provided within a reasonable time, 24 hours a day, every day of the year under the same rules that apply for the community’s contracted pharmacy.

8. The monthly community processing fee is: _______________. This charge will be included in the resident’s monthly invoice.

**Resident/ Responsible Party’s Responsibilities:**
The resident/responsible party must provide the community with an emergency contact (name and phone number) in case the outside pharmacy fails to meet the regulations as outlined above.

1. Resident/Responsible party agrees to pay any charges which occur due to delay in receiving medication from the outside pharmacy. The parties understand that the designated community staff person will obtain the needed medications from the community’s pharmacy if the medication is not received on time from the outside pharmacy. Charges may include emergency delivery fees, the cost of the medications, and any related medical supplies.

2. Resident/Responsible party will provide a 30 day written notification to the Executive Director if a change in pharmacy provider will be made. In this instance a new agreement will be signed.
3. Resident/Responsible party understands that ordering medication outside the community’s normal provider may complicate the safe and timely administration of medication services and if the outside pharmacy and/or resident/responsible party cannot meet the guidelines outlined in this agreement; the community will reserve the right to withdraw this privilege, after consultation with those involved. At this juncture a new pharmacy vendor will be secured and a new agreement will be signed.

OUTSIDE PHARMACY INFORMATION:

Company Name: ________________________________
Address: ______________________________________
Normal Business Number:_____________ Emergency Number:__________
Facsimile Number: ____________________________

RESPONSIBLE PARTY CONTACT INFORMATION:

Contact Name: ________________________________ Relationship: _______________
Home #: ________________________________ Cell #: ____________________________

ALTERNATE PARTY CONTACT INFORMATION:

Contact Name: ________________________________ Relationship: _______________
Home #: ________________________________ Cell #: ____________________________

I fully understand the conditions outlined in this agreement and will uphold all responsibilities listed herein.

Resident ________________________________ Date ________________________________

Responsible Party ________________________________ Date ________________________________

Executive Director/Community Designee ________________________________ Date ________________________________

Pharmacy Representative ________________________________ Date ________________________________