

Iowa Prescription Drug Corporation Network Pharmacy Agreement

This agreement between the Iowa Prescription Drug Corporation (IPDC), 11100 Aurora Avenue, Urbandale, IA 50322, an Iowa based not-for-profit corporation, and _____, address _____, an Iowa licensed pharmacy, is effective as of September 1, 2009 and will remain in effect until IPDC notifies the above named pharmacy that the agreement has been terminated. Notification will be transmitted by FAX. The above named pharmacy may elect to terminate this agreement by giving a 30 day notice by FAX or mail to IPDC.

Upon acceptance of this agreement, the above named pharmacy agrees to accept and fill a prescription for a 90 day course of treatment when a customer presents a medication voucher (Attachment A) and a prescription for any of the medications listed on the IPDC Pharmaceutical Program Formulary (Attachment B). The quantity of the medication dispensed is not to exceed that which is specified in the formulary.

The customer shall present a medication voucher and a prescription to the participating pharmacy, or may obtain a medication voucher from the participating pharmacy. In order to qualify for a voucher, the customer must meet the eligibility requirements of this program: They must be an Iowa resident, have no insurance that provides prescription drug coverage at the time the prescription is to be filled, and must be in need of financial assistance. The customer must have, or be given, a medication voucher for each prescription that is to be filled.

The above named pharmacy shall collect a co-pay of \$3.00 from the customer for each 90 day supply of medication they dispense. The pharmacy will receive \$7.00 from IPDC for each prescription/medication voucher filled. If the pharmacy determines that the customer is in need, they may elect to waive the \$3.00 co-pay and bill IPDC \$7.00 for the filled prescription in extreme hardship situations. The pharmacy must retain the voucher for six months for audit purposes. At the end of the six month period, the voucher can be destroyed.

The above named pharmacy must either FAX, E-mail or mail to IPDC a printout or a list which includes the patient's date of birth, gender, the name and strength of the medication, the quantity of units (i.e, tablets) of each of the medications that were dispensed, the voucher number, whether the \$3.00 co-pay was waived by the pharmacy and the county number where the script was filled. This information must be submitted to IPDC by midnight of the fifth day of each month to insure timely reimbursement. All information received by IPDC will be considered confidential and will be protected under the Health Insurance Portability and Accountability Act (HIPAA).

IPDC shall reimburse the above named pharmacy the sum of \$7.00 for each medication voucher/prescription filled during the previous month. All participating pharmacies must complete, sign and return the enclosed Direct Deposit Authorization Agreement and this completed and signed agreement. Deposits will be made to your account no later than the 20th of the month following submission of the printout or list of prescriptions filled during the previous month. If the printout or list is not received by midnight of the fifth day of each month, your reimbursement may be delayed.

All participating materials and monthly lists or printouts may be FAX to 1-515-327-5422, e-mailed to info@iowapriority.org or sent to the IPDC, 11100 Aurora Ave. Bldg 13, Urbandale, IA 50322.

Upon signature the below named pharmacy accepts the conditions above and elects to participate in this program:

Signature _____ Title _____

Name of Pharmacy _____

Address _____

City _____

State _____

Telephone Number _____

FAX number _____