521 4th Street Havre, Montana 59501 • Phone: 406-395-4305 •Fax: 406-395-5643 • www.bullhook.com

POLICY

PFIZER SHARE THE CARE PRESCRIPTION SAVINGS PROGRAM 8030

POLICY:

1. To qualify, patients must meet income guidelines, be without public or private prescription drug coverage and be qualified on an annual basis.

2. Patients will be required to verify income and sign **Patient Intake Form."** The date the form is signed will be recorded as EFFECTIVE DATE in payment info and the Expiration Date will be no more than 1 year later. If effective dates and expirations dates are not in place, the pharmacy operating system will not allow the STC plan designations to be used.

    - Patients will need to re-enroll on an annual basis to include:

        1. Pharmacy Patient STC Intake form
            a. Patients completed this form in its entirety, and sign and date
            b. Pharmacy screener verifies completeness and review by their initials and date

        2. Proof of income – current proof of income is provided from the Eligibility Department; and may include but not limited to:
            - Current year Tax Return
            - Paycheck Stubs – one (1) month
            - Office of Public Assistance Benefit (Food Stamp Benefit History)
            - Pension
            - Social Security or Bank Statement Showing Deposits
            - Signed Personal Letter Verifying Financial Status, Housing Situation
            - Letter on Agency Letterhead Verifying Financial Status
            - Student Grant Information

        3. Verification from Website for Medicaid as homeless are qualified every six (6) months

3. Patients who qualify through BCHC's A-D slide will qualify for the program.

4. Patients are further assigned the bill code of STC by Pharmacy personnel.

5. Record retention period for patient records and required source documentation is 3 years (hard copy or electronic). This includes but is not limited to patient eligibility, source documentation, product receipt, inventory, dispensing, distribution, return records and prescriptions.

6. Orders are created once a month at the end of each month by utilizing the pharmacy software database and will not be generated until after the return to stock process has been competed to ensure only physically dispensed Program product is requested. Before the order is created BHC pharmacy personnel will run a report to ensure:

   - No product is used in any plan designations not listed above.
   - If RX is filled but not picked up it will be voided within pharmacy software and rerun on new date to be submitted in the next month, if it was filled in the last 10 days of the month.
   - If RX is filled but not picked up and is more then 10 days before the end of the month, it will be voided and placed back in STC stock.
   - The Lead Technician or other trained personnel verifies the request for replenish-ment report to ensure all required information complete and in the format required by Program Administration

   The following fields are submitted to Pfizer when placing request:

   - Product Name
   - Product Strength
   - NDC#
   - Unique Patient ID#
   - Date of Birth
   - Gender (preferred/not required)
   - Rx Number
   - Date Dispensed
   - # of Tablets Dispensed
   - # of bottles if liquid (ml)
   - Number of days of therapy dispensed (i.e., 30, 60, 90 day supply)

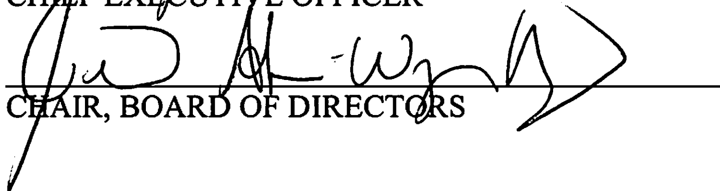
7. Upon receipt of requested Program Products, a fax will be received from the STC Program Administrator requesting confirmation of the actual volume/number of units received per NDC. The confirmation must be completed and faxed.

   - Product will be checked against the packing list then initialed and dated by the person responsible
   - Product will be checked against the replenishment report request to ensure what was asked for is received.
   - Replenishment report is obtained from STC web site and faxed back with the packing list to STC.
   - Any discrepancies will be noted and the Program Administrator will be contacted at this time.

8. Lost, stolen or returned product will be reported to the Pfizer STC Program Administrator as soon as possible.

9. At the time of enrollment, and each subsequent prescription after, it will be verified that the enrollee does not have Medicaid or Medicare coverage. Documentation will be preserved with the "**Patient Intake Form**". (See attached form.)

CHIEF EXECUTIVE OFFICER Date: 11-25-14



CHAIR, BOARD OF DIRECTORS Date: Nov 25, 2014

Date first adopted	09/24/2014
Date revised/QI	09/24/2014
New date adopted/Board	10/13/2014
Next review date	10/13/2015

Attachment

BULLHOOK COMMUNITY HEALTH CENTER
PATIENT INTAKE FORM

PATIENT INFORMATION: (Who is being seen today)

Last Name:________________ First Name:____________ Date of Birth ______

SSN: ________________

Are you homeless? [ ] YES [ ] NO

Family Size:__________

INSURANCE COVERAGE
Check all that apply: [ ] **NONE**

[ ] Mental Health [ ] Medicaid [ ] Medicare **PART D** [ ] Private Insurance [ ] Blue Chip [ ] Indian Health [ ] VA

BULLHOOK COMMUNITY HEALTH CENTER
521 FOURTH STREET
Havre, MT 59501
406-395-4305

AUTHORIZATION AND ACKNOWLEDGEMENT

The information given on this form is true to the best of my knowledge. Treatment/Payment Agreement for Bullhook Health Center (BHC).

I request the above to provide me and/or my family with program medications. I understand and agree to communicate to BHC all changes to my income and/or insurance status.
I understand and give consent for my information to be accessed by outside entities for the purposes of auditing the facilities compliance with federal, state and pharmaceutical program business rules.

Signed______________________________ **Date**______________

FINANCIAL STATUS WORKSHEET. VERIFY ALL SOURCES OF GROSS INCOME (PROOF OF INCOME IS NECESSARY TO QUALIFY FOR SLIDING FEE)

Family Income	$	No
Wages		
Self Employment		
Unemployment		
Workers Compensation		
Retirement/Pension		
Social Security		
Disability		
Food Stamps		
Child Support		
Alimony		
Other (please indicate)		