NEW HOME IMPLEMENTATION

FACILITY INFORMATION

Name of Facility: _____

DBA: _____

Address: _____

_____

Telephone Number: (_____) _____ Fax Number: (_____) _____

Administrator: _____E-mail_____

Director of Nursing: _____E-Mail_____

Assistant D O N: _____E-Mail_____

In-service Coordinator: _____E-Mail_____

Medical Director: _____E-Mail_____

IT Department Contact:_____E-Mail_____

Dispensing Method: _____ Current Dispensing Method: _____

Start Date: _____

Maximum Census: (licensed beds) _____ Todays Census: _____

NUMBER OF BEDS	LTC: _____	Asst Living: _____	Residential: _____	
	Other:		Total Beds:	

Reports and Statements: Please provide name and email

Who should pharmacy contact to inform when triplicate is needed: _____

A/R Statements sent to: _____

Med Availability Report: _____

Medicaid Pending report sent to: _____

Weekly Facility Billing Pending report sent to: _____

MTD reports: _____

Facility Name: _____

NURSING STATIONS		
Name	Room (range)	Contact Person Extension
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

FACILITY IMPLEMENTATION

1. Will M Chest Pharmacy be using Therapeutic Interchange protocols? . . . . . Yes ◉ No ○
2. Will M Chest Pharmacy be providing the flu vaccine? Yes ◉ No ○
3. Will M Chest Pharmacy provide Hospice related medications? Yes ○ No ◉

Name/Company/Email of consultant pharmacist:

FACILITY SUPPLIES

Standard E-kit . . . . . Yes ○ No ◉

Location: _____ Quantity:_____

Narcotic E-kit . . . . . Yes ○ No ◉

Location: _____ Quantity:_____

IV E-kit . . . . . Yes ○ No ◉

Location: _____ Quantity:_____

Will M Chest Pharmacy provide OTC medications . . . . . Yes ○ No ◉

Stock Medications . . . . . Yes ○ No ◉

Location: _____

Each Unit . . . . . Yes ○ No ◉ Central Location . . . . . Yes ◉ No ○
Facility List . . . . . Yes ◉ No ○

Delivery date to facility of supplies: _____

NEW HOME IMPLEMENTATION

FACSIMILE MACHINE INFORMATION

Name of Facility: _____

Does facility own fax lines? . . . . . Yes ◒ No ❍

Location: _____ Lines: (_____) _____

Location: _____ Lines: (_____) _____

Location: _____ Lines: (_____) _____

Location: _____ Lines: (_____) _____

Location: _____ Lines: (_____) _____

Location: _____ Lines: (_____) _____

Location: _____ Lines: (_____) _____

Location: _____ Lines: (_____) _____

Anything special to dial out of building? _____

NUMBERS TO BE PROGRAMMED

M Chest Main ❍ **Phone**_____ **Current Pharmacy fax** _____

Installation Date Needed By: _____

NEW HOME IMPLEMENTATION

FACILITY DELIVERY INFORMATION
Name of Facility:_____
Address: _____
Telephone Number: (_____) _____
Start Date: _____
Delivery Entrance: _____ Door Code: _____

Number of Deliveries			
◯ One	◯ Two		

Cut Off Times
Refills:
New Orders / Admission or Re-Admissions

Refills:
New Orders / Admission or Re-admissions Weekends

Delivery Locations Inside
Unit: _____
Unit: _____
Unit: _____
Unit: _____
Unit: _____
Unit: _____
Unit: _____
Unit: _____

NEW HOME IMPLEMENTATION

EQUIPMENT INFORMATION				
Type:	Box	Vial	Bingo	Other

Medication Carts . . . . . Yes ◉ No ○ Quantity: _____ Dividers…….. Yes ◉ No ○

Tx Carts . . . . . Yes ◉ No ○ Quantity: _____ Dividers…….. Yes ◉ No ○

Cart Supplier: _____

Notified . . . . . Yes ◉ No ○ By: _____ Date: _____

Delivery Date: _____

New carts: Send information including pictures of current carts to Director of Operations to initiate quote process if necessary

INSERVICING INFORMATION

Framework Link - training to be provided to: Schedule – time and place – routinely when scheduled

_____ _____

_____ _____

THERAPEUTIC SUBSTITUTIONS INFORMATION

Therapeutic substitution discussed? . . . . . Yes ◉ No ○

Point Person: _____ Title: _____

FACILITY SUPPLIES

Policy and Procedure Manuals IV Manuals

Quantity:_____ Quantity:_____

Delivery date of Manuals: _____

Medication Binders . . . . . Yes ◉ No ○ Qty: _____ Dividers: _____

Treatment Binders . . . . . Yes ◉ No ○ Qty: _____ Dividers: _____

Delivery Date of Binders: _____

FACILITY CREDENTIALS (SEND TO THE ATTENTION OF THE DIRECTOR OF NURSING)

DEA License
Pharmacy License
Liability insurance
RPH in Charge License
Delivery date of Credentials: _____

Dear Valued Customer, Thank you for choosing M Chest Pharmacy as your provider pharmacy. We appreciate your confidence in allowing us to service your facility. Enclosed you will find a list of credentials that may be needed during Department of Health Survey.

BILLING OFFICE INFORMATION

Please note that the Billing Manager will contact the Billing Office to schedule a visit to review all billing procedures.

Name of Facility: _____

Contact Person: _____ Title: _____

Telephone Number: (_____) _____ Ext: _____

Contact person for private pay / Medicare charges review: _____

Name of person responsible for sending daily census: _____

Special specs/criteria for billing export: _____

_____

MED D INFORMATION

Point Person: _____ Title: _____

Fax Number: _____

HIGH COST THRESHOLD INFORMATION (PRE-FILL)

Dollar Amount: _____

Approval Authorazation:_____

_____

If above not reachable: Send Full Amount Yes ○ No ◉

Send Short Supply Yes ○ No ◉ Number of days:_____

INSURANCE NON-COVERED MEDICATION POLICY

Send Short Supply Yes ◉ No ○ Number of Days:_____

Send Full Amount Yes ◉ No ○

Only Send if Under Certain Dollar Amount Yes ◉ No ○ Dollar Amount:_____

PRIVATE PAY MEDICATION POLICY

Send Short Supply Yes ◉ No ○ Number of Days:_____

Send Full Amount Yes ◉ No ○

Only Send if Under Certain Dollar Amount Yes ◉ No ○ Dollar Amount:_____

Private Pay residents will be given up to $100 credit limit upon admission. Once the pharmacy receives the completed admission packet, including responsible party information, insurance cards and credit card authorization, the credit limit will be increased up to $1,000.

DRUG RETURN POLICY

MChest Pharmacy Group, LLC and each of its subsidiaries ("Pharmacy") accepts the return of unused prescription medications that are still in their original packaging, have been delivered, and paid for by a facility ("Facility Paid Items") if certain criteria are met. Prescription medications paid for by the patient or the patient's insurance will only be returnable if the facility refuses to accept delivery of these medications because patient has discharged, is deceased or the medication has been cancelled by the patient's physician.
Facility Paid Items will be evaluated using the criteria listed below to determine eligibility for return. If applicable, prescription medications that are covered by a per diem rate are considered returnable; however, no credit will be given.

DRUG CATEGORIES

Non-Returnable Items

The following Facility Paid Items are not returnable after being delivered to the facility.

- Prescription medications that have not been returned to Pharmacy within 60 days from the dispense date (dispense date as printed on the prescription label)
- Controlled Substances (DEA Class CII-CV)
- Refrigerated/Frozen Items
- Special Order Medications (not stocked due to dispensing frequency and / or cost, determined by Pharmacy)
- OTC Products
- Compounded Medications (including IV's)
- Prescriptions dispensed in partial tablets
- Partial prescriptions whose returnable value is less than the $5.00 restocking fee

Full and/or Partial Quantity Items

The following Facility Paid Items are returnable in either full or partial quantities if they are not excluded by one or more of the Non-Returnable categories listed above. A partial quantity is defined as any quantity less than the dispensed quantity.

- Solid/Oral Prescription Medications
- Single-Use Syringes (i.e. Enoxaparin)
- Individually Wrapped Patches (i.e. Exelon, Lidocaine, Rivastigmine)

Full Quantity Items

All other Facility Paid Items that fall outside of the two categories listed above are returnable as long as the manufacturer's seal has not been broken.

FACILITY IMPLEMENTATION

30 DAYS PRIOR TO START

1. Send signed contract to the pharmacy
2. Set date and time for in-service (see pg. 6)
3. Face sheets and orders send to the pharmacy
4. Physician list to include Name – Address – Telephone – DEA – License Number
5. Current census
6. Obtain a copy of latest **SIGNED** physician's orders for each resident
7. Provide facility with conversion letter to be sent to all residents
8. Make a copy of the E-kit license (blue) and DPS Narcotic license and put copies in place of the original at the facility. Mail originals to the pharmacy
9. Provide designated agent forms to the DON and instructions on getting one filled out for each prescriber

7 DAYS PRIOS TO START

1. Pharmacy will requests face sheets of all new admits prior to start date
2. Facility to provide **SIGNED** Designated Agent Forms
3. Facility to provide **SIGNED** Therapeutic Interchange forms
4. Facility to print current copy of physician orders and send to M Chest Pharmacy (unless integrated)
5. Complete census to be provided daily

NEW HOME IMPLEMENTATION

NAME OF FACILITY: _____

I hereby certify that I have reviewed the information contained in this packet and verify the information as accurate.

Signature of facility representative: _____ Title:_____

Dear Resident and / or Family Member:

Thank you for choosing M Chest Pharmacy as your pharmacy service provider! The entire team here knows what an important role pharmacy services provides in caring for you or your loved one and we hope to take a few minutes to explain some of the services to you as well. While you may be used to working with a retail pharmacy in the past, M Chest is very different from that experience, but yet very cost competitive as you will see. Here are a few of the services that are being provided and go above and beyond your typical retail pharmacy:

- 24 hours /7 days a week/ 365 days a year service
- Numerous deliveries a day at no charge to you
- Staff in-servicing and education
- Knowledgeable Billing Department to assist you in all aspects of pharmacy drug coverage
- Emergency medication systems "in-house" for prompt medication access

In order to establish an account with M Chest Pharmacy, we will need the following information returned to us. Upon receipt of basic resident information and a copy of your prescription insurance cards (typically submitted by the facility staff) and prior to receiving the Pharmaceuticals Purchase Agreement and Assignment of Benefits forms, M Chest Pharmacy will setup a temporary account for you that will be limited to $100 in total charges and these charges will be due upon receipt of your invoice at the end of each month. Once MChest has received all of your signed forms, your account credit limit will be increased to $1,000 and you will be setup with 30 day payment terms. This means your monthly invoice will be due 30 days after the invoice date.

COPY & SEND	**Resident Information** (form provided or facility may send on separate form) **Prescription Insurance Card(s)**
SIGN & RETURN	**Pharmaceuticals Purchase Agreement** **Assignment of Benefits**

Please feel free to contact our billing office at **1-800-734-9105** if you have any questions or concerns. In addition, if you feel we do not have current or accurate insurance information, we will gladly accept the information over the phone, or by fax at **(469) 206-5937**.

We thank you again for the opportunity to serve you or your family member!

Sincerely,

M Chest Pharmacy

E-KIT USAGE NOTIFICATION

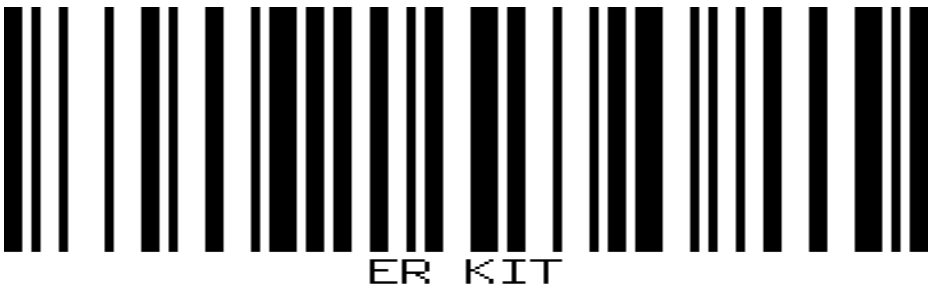
Facility_____ **Wing**_____

Patient_____ **Date**_____

Physician_____ **Time**_____AM /PM

Medication	Strength	Directions	Qty Used/ Remaining
			/
			/
			/
			/
			/
			/
			/

Nurse's Signature_____



PLEASE FAX COMPLETED FORM TO THE PHARMACY EVERY TIME A MEDICATION IS REMOVED FROM THE ER KIT.

TEMPLATE
CONTROL E-KIT LIST

Drug Name	QTY
ALPRAZOLAM TAB 0.5MG	8
APAP/CODEINE TAB 300-30MG	8
CLONAZEPAM TAB 0.5MG	4
DIAZEPAM TAB 2MG	8
DIPHEN/ATROP TAB 2.5MG	4
LORAZEPAM TAB 0.5MG	8
LYRICA CAP 25 MG	4
ZOLPIDEM TAB 5MG	4
HYDROCODONE 5/325	6
HYDROCODONE 10/325	6
TRAMADOL HCL TAB 50MG	8
OXYCODONE 5/325	6
OXYCODONE 10/325	4

STANDARD E-KIT LIST

Items	**Qty**
ANTIBIOTICS	
AMOX/K CLAV TAB 500-125	7
AMOX/K CLAV TAB 875-125	7
AMOXICILLIN CAP 250MG	28
AZITHROMYCIN TAB 250MG	20
CEFDINIR CAP 300MG	7
CEFUROXIME TAB 250MG	14
CEPHALEXIN CAP 250MG	14
CIPROFLOXACN TAB 250MG	28
CLINDAMYCIN CAP 150MG	14
DOXYCYCL HYC CAP 100MG	14
FLUCONAZOLE TAB 50 MG	12
LEVOFLOXACIN TAB 250MG	28
LINEZOLID 600 MG	10
METRONIDAZOL TAB 250MG	14
NITROFUR MAC CAP 50MG	7
NITROFURANTN CAP 100MG	14
SMZ/TMP DS TAB 800-160	14

STANDARD E-KIT LIST

ALBUTEROL NEB 0.083%	10
ALLOPURINOL 100 MG	6
AMIODARONE TAB 200MG	8
AMLODIPINE TAB 5MG	8
ATORVASTATIN TAB 10MG	4
BENZONATATE CAP 100MG	6
CARBAMAZEPIN TAB 200MG	6
CARB/LEVO ER TAB 25-100MG	9
CARVEDILOL TAB 3.125MG	8
CITALOPRAM TAB 20MG	4
CLONIDINE TAB 0.1MG	6
CLOPIDOGREL TAB 75MG	4
CYCLOBENZAPR TAB 5MG	3
DIGOXIN TAB 0.125MG	3
DIVALPROEX CAP 125MG	8
DIVALPROEX TAB 250MG DR	6
DIVALPROEX TAB 250MG ER	6
DONEPEZIL 5 MG	6
DULOXETINE CAP 30MG	3
ESOMEPRA MAG CAP 40MG DR	4
FLUOXETINE CAP 20MG	4
FOLIC ACID TAB 1MG	4
FUROSEMIDE TAB 20MG	3
GABAPENTIN CAP 100MG	12
GLIPIZIDE TAB 5MG	3
GLUCOSE CHW 4GM	3
GLYBURIDE TAB 2.5MG	3

STANDARD E-KIT LIST

HALOPERIDOL TAB 0.5MG	3
HYDRALAZINE TAB 25MG	6
HYDROXYZ HCL TAB 25MG	3
HYDROCHLOROT TAB 25MG	3
IPRATROPIUM SOL 0.02%INH	10
IPRATROPIUM-ALBUTEROL 0.5 - 3 MG UD VIAL	10
ISOSORB MONO TAB 30MG ER	3
LACTULOSE SOL 10GM/15	4
LANSOPRAZOLE CAP 30MG DR	4
LEVOTHYROXIN TAB 100MCG	4
LEVOTHYROXIN TAB 50MCG	4
LISINOPRIL TAB 5MG	4
MEMANTINE TAB HCL 5MG	4
METFORMIN TAB 500MG	8
METHYLPRED TAB 4MG	8
METOCLOPRAM TAB 5MG	12
METOLAZONE TAB 2.5MG	3
METOPROL TAR TAB 25MG	8
METOPROLOL TAB 25MG ER	4
MIRTAZAPINE TAB 15MG	6
MONTELUKAST TAB 10MG	4
NITROGLYCERN SUB 0.4MG	1
OLANZAPINE TAB 2.5MG	6
OMEPRAZOLE CAP 20MG	8
ONDANSETRON TAB 4MG	12
PANTOPRAZOLE TAB 20MG	4
PANTOPRAZOLE TAB 40MG	4
PHENAZOPYRID TAB 100MG	6

STANDARD E-KIT LIST

PHENYTOIN EX CAP 100MG	9
POT CHLORIDE CAP 10MEQ ER	6
POT CL MICRO TAB 20MEQ ER	6
PREDNISONE TAB 5MG	12
PREDNISONE TAB 20 MG	8
PROMETHAZINE TAB 25MG	12
QUETIAPINE TAB 25MG	6
RISPERIDONE TAB 0.25MG	6
SERTRALINE TAB 50MG	6
SIMVASTATIN TAB 20	4
SPIRONOLACT TAB 25MG	6
SPS SUS 15GM/60	4
TAMSULOSIN CAP 0.4MG	3
TRAZODONE TAB 50MG	6
WARFARIN TAB 1MG	6
WARFARIN TAB 2.5MG	6
WARFARIN TAB 3 MG	6

STANDARD E-KIT LIST

INJECTABLES	
CEFTRIAXONE INJ 1GM	3
CEFEPIME INJ 1 GM	3
CIPROFLOXACIN 400MG/200 ML	2
CYANOCOBALAM INJ 1000MCG	1
DIPHENHYDRAM INJ 50MG/ML	2
ENOXAPARIN INJ 60 MG/ML	2
ENOXAPARIN INJ 40 MG/ML	2
EPINEPHRINE INJ 1MG/ML	2
FUROSEMIDE INJ 10MG/ML	2
GENTAMICIN INJ 40MG/ML	4
GLUCAGEN INJ HYPOKIT	2
HALOPER LAC INJ 5MG/ML	1
HEPARIN SOD INJ 5000/ML	2
KENALOG-40 INJ 40MG/ML	1
LEVOFLOX/D5W INJ 250/50ML	2
LIDOCAINE INJ 1%	3
METHYLPR SS INJ 125MG	2
NALOXONE INJ 0.4MG/ML	4
OLANZAPINE INJ 10MG	1
ONDANSETRON INJ 4MG/2ML	4
PIPER/TAZOBA INJ 3-0.375G	3
PROMETHAZINE INJ 25MG/ML	4
VANCOMYCIN 1 GM VIAL	2
VANCOMYCIN 500 MG VIAL	2
VITAMIN K1 INJ 10MG/ML	2

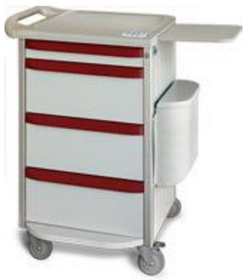
STANDARD IV KIT

1" GRIPPER
BUTTERFLY NEEDLE
CLAVE EXTENSION SET 7.25"
CLAVE INJECTION SITE CONN
D5W/NACL INJ 0.45%
D5W/NACL INJ 0.9%
DEXTROSE INJ 5%
DIAL-A-FLO
DRESSING CHANGE TRAY
FILTER SET (MACROBORE)
HEPARIN LOCK INJ 10UNT/ML
IV START KIT
SAF-T-INTIMA 20G
SAF-T-INTIMA 22G
SAF-T-INTIMA 24G
SOD CHLORIDE INJ 0.45%
SOD CHLORIDE INJ 0.9%
SODIUM CHLORIDE 0.9% SYG
STERIL WATER INJ
VOLUMAT SET

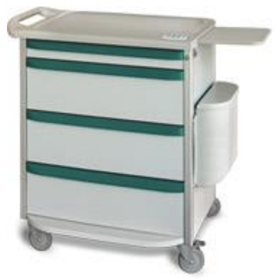
STANDARD REFRIGERATOR E-KIT

Drug Name	QTY
LANTUS INJ 100/ML	1
LEVEMIR INJ	1
NOVOLIN INJ 70/30	1
NOVOLIN R INJ U-100	1
NOVOLOG INJ 100/ML	1

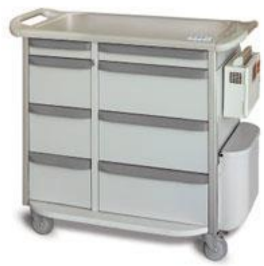
☐ **Determine with the DON/Administrator the number and types of med / treatment carts needed**



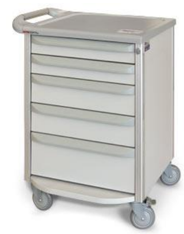
M3 – 350 CARDS



M4 – 450 CARDS



M5 – 550 CARDS



TREATMENT CART

Cart Size	Qty	Color	Souflette	Trash	Sharps	Single Lock Box	Double Lock Box
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐
Choose Cart Size		Green	☐	☐	☐	☐	☐

Please send all Med Carts pictures and needs to the Director of Operations, Pharmacy Manager and Amanda Herrick. Cart appearance may differ from images above at based on supplier chosen by M Chest.