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		
Unit Name	Wing/Hall/Room#/Bed (Match EMAR mapping)	Contact Person Extension
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Integration:

What EMAR system do you currently use, (PCC, Matrix)? _____

Will the facility be integrating with the pharmacy? _____

Who is the facility contact for integration? _____

Has your current EMAR provider been provided the necessary paperwork to convert to our pharmacy? _____

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	Notes:

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: _____

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 Three (3) Day Supply Yes ❍ No ❍

INSURANCE NON-COVERED MEDICATION POLICY

Send Three (3) Day Supply Yes ❍ No ❍

Send Full Amount Yes ❍ No ❍

Only Send if Under Certain Dollar Amount Yes ❍ No ❍ Dollar Amount:_____

PRIVATE PAY MEDICATION POLICY

Send Three (3) Day Supply Yes ❍ No ❍

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:_____

E-KIT USAGE NOTIFICATION

Facility_____**Wing**_____

Patient_____ **Date**_____

Physician_____ **Time**_____AM / PM

Medication	Strength	Serial #	Directions	Qty Used/ Remaining
				/
				/
				/
				/
				/
				/
				/

Nurse's Signature_____

E-Kit Serial #:_____

ER KIT

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

☐ **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		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐
Choose Cart Size		Choose Color	☐	☐	☐	☐	☐

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.