



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: _____ Todays Census: _____ (licensed beds)			
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 <input type="radio"/> No <input type="radio"/>	
Location: _____	Quantity: _____
Narcotic E-kit Yes <input type="radio"/> No <input type="radio"/>	
Location: _____	Quantity: _____
IV E-kit Yes <input type="radio"/> No <input type="radio"/>	
Location: _____	Quantity: _____
Will M Chest Pharmacy provide OTC medications Yes <input type="radio"/> No <input type="radio"/>	
Stock Medications Yes <input type="radio"/> No <input type="radio"/>	
Location: _____	
Each Unit Yes <input type="radio"/> No <input type="radio"/>	Central Location Yes <input type="radio"/> No <input type="radio"/>
Facility List Yes <input type="radio"/> No <input type="radio"/>	
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		
<input type="radio"/> One	<input type="radio"/> 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 <input type="radio"/> No <input type="radio"/>	Quantity: _____	Dividers.....	Yes <input type="radio"/> No <input type="radio"/>
Tx Carts	Yes <input type="radio"/> No <input type="radio"/>	Quantity: _____	Dividers.....	Yes <input type="radio"/> No <input type="radio"/>
Cart Supplier: _____				
Notified				
Yes <input type="radio"/> No <input type="radio"/> 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 <input type="radio"/> No <input type="radio"/>				
Point Person: _____ Title: _____				
FACILITY SUPPLIES				
Policy and Procedure Manuals		IV Manuals		
Quantity: _____		Quantity: _____		
Delivery date of Manuals: _____				
Medication Binders				
Yes <input type="radio"/> No <input type="radio"/> Qty: _____ Dividers: _____				
Treatment Binders				
Yes <input type="radio"/> No <input type="radio"/> 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

M Chest 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 M Chest 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

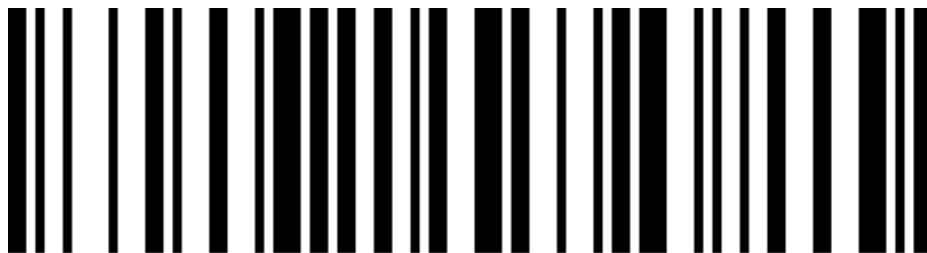
Facility _____ Wing _____

Patient _____ Date _____

Physician _____ Time _____ AM /PM

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

Nurse's Signature _____



ER KIT

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

<i>Items</i>	<i>Qty</i>
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
PREDNISON TAB 5MG	12
PREDNISON 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	
CEFTRIAZONE 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	Soufflette	Trash	Sharps	Single Lock Box	Double Lock Box
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choose Cart Size		Choose Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.