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Magellan Rx MANAGEMENT℠

Independent Pharmacy Recredentialing Form

Completed forms can be sent to:

Fax 888-656-3520 OR Email Credentialing1@magellanhealth.com

SECTION A: PHARMACY/OWNERSHIP INFORMATION

NCPDP #: _____ NPI #: _____

Provider Legal Name: _____

Provider D/B/A: _____

Physical Address: _____ Suite #: _____

City: _____ County: _____ State: _____ Zip Code: _____

Telephone #: _____ Fax #: _____ Email: _____

Ownership Entity or Individual(s) Name: _____

PIC (Pharmacist in Charge) First Name: _____ Last Name: _____

PIC License Number: _____ State: _____ Expiration Date: _____

Have you changed ownership in the last 12 months?

☐ Yes ☐ No If yes, date opened/acquired: _____

Federal Tax ID: _____

State Tax ID: _____

Medicare #: _____

Medicaid Number #: _____

Medi-Cal # (CA Only): _____

State License #: _____ State License Expiration Date: _____

DEA #: _____ DEA Expiration Date: _____

Software Vendor(s): _____ Switch Company: _____

Wholesaler (List All): _____

SECTION B: 340 (B)

1. Is your pharmacy considered a 340B Pharmacy?
   ☐ Yes ☐ No If no, please disregard this section.
2. Is your pharmacy owned by a 340B Covered Entity?
   ☐ Yes ☐ No HRSA 340B ID Number: _____

SECTION C: MAIL ORDER/DELIVERY

1. Does your pharmacy deliver prescriptions?
   ☐ Yes ☐ No
2. Does your pharmacy mail prescriptions via USPS, UPS, Fed-Ex, etc.?
   ☐ Yes ☐ No
3. If yes, what percentage of your business is dedicated to mail? _____ %
4. Is your pharmacy licensed in each state that you mail to?
   ☐ Yes ☐ No
5. Pharmacy agrees to provide copy(s) of applicable non-resident licensure upon request?
   ☐ Yes ☐ No
6. Please list each state that pharmacy mails or intends to mail prescriptions to:

   _____
7. Is your pharmacy URAC Accredited?
   ☐ Yes ☐ No Accreditation Date: _____
8. Does your pharmacy have Digital Pharmacy Accreditation?
   ☐ Yes ☐ No Accreditation Date: _____

SECTION D: SPECIALTY

1. Are you considered a Specialty Pharmacy?
   ☐ Yes ☐ No If no, please disregard this section.
2. What percentage of your business is dedicated to specialty? _____ %
3. Is your pharmacy URAC Accredited?
   ☐ Yes ☐ No Accreditation Date: _____
4. Does your pharmacy have Digital Pharmacy Accreditation?
   ☐ Yes ☐ No Accreditation Date: _____
5. Is your pharmacy ACHC Accredited?
   ☐ Yes ☐ No Accreditation Date: _____

SECTION E: COMPOUNDING

1. Does your pharmacy process Compound Drug claims?
   ☐ Yes ☐ No If no, please disregard this section.
2. What percentage of your business is dedicated to compounding? _____ %
3. Does your pharmacy perform Sterile Compounding?
   ☐ Yes ☐ No
4. Is your pharmacy accredited, certified, and/or licensed for Sterile Compounding?
   ☐ Yes ☐ No If yes, by what Organization? _____

*** Additional credentialing may be required to compound.

SECTION F: GENERAL QUESTIONS

1. Is your pharmacy currently in good standing with the State Board of pharmacy and/or other Federal or State licensing authorities?
   ☐ Yes ☐ No If no, provide a letter of explanation.
2. Has your pharmacy ever been terminated by a third-party payor, prescription benefit management organization, managed care organization, or other similar organization(s)?
   ☐ Yes ☐ No If yes, please explain on a separate sheet of paper.
3. Does your pharmacy have a policy to destroy and/or return expired medications?
   ☐ Yes ☐ No
4. Is your pharmacy easily accessible and open to the public?
   ☐ Yes ☐ No
5. Does your pharmacy remediate medication situations related to manufacturer recalls?
   ☐ Yes ☐ No
6. Does your pharmacy have a process to track, log, and report medication errors and report to Magellan and/or appropriate agencies?
   ☐ Yes ☐ No
7. Does your pharmacy have any offshore activity that involves the use of Protected Health Information (PHI)?
   ☐ Yes ☐ No If yes, please explain _____
8. Does your pharmacy have a policy in place to comply with the regulations to safeguard/secure Protected Health Information (PHI)?
   ☐ Yes ☐ No
9. My pharmacy staff, pharmacist, technicians, and other staff performing pharmacy services have been provided code of conduct and standards of practice policies and procedures within 90 days of hire and annually thereafter.
   ☐ Yes ☐ No

10. My pharmacy staff, pharmacist, technicians, and other staff performing pharmacy services have completed Fraud Waste and Abuse training within 90 days of hire and annually thereafter.

    ☐ Yes ☐ No

11. Upon Hire, and every 30 days thereafter, my pharmacy will review the Office of Inspector General List of Excluded Individuals and Entities (LEIE) and General Services Administration (GSA) for all employees, owners, officers, agents, or contractors providing services directly or indirectly to a covered individual to determine if they have been excluded from participation in Medicare, Medicaid, or any Federal Health care program and will notify Magellan immediately of any exclusion information discovered.

    ☐ Yes ☐ No

12. My participating pharmacy managers, officers, and directors are free from any conflict of interest in administering and delivering prescription services related to Medicare Part D beneficiaries.

    ☐ Yes ☐ No

13. I login to NCPDP regularly and update my profile to ensure the most accurate and up-to-date information is available.

    ☐ Yes ☐ No

14. Returned with this document, I have included the following:

    a. Pharmacy License – Must not expire in the next 30 days.

       ☐ Yes ☐ No

    b. Full Unrestricted DEA – Must not expire in the next 30 days.

       ☐ Yes ☐ No

    c. Certificate of Liability Insurance. Coverage – $1,000,000 per occurrence and $3,000,000 in aggregate per policy year, must not expire in the next 30 days.

       ☐ Yes ☐ No

    d. Disclosure Form

       ☐ Yes ☐ No

I certify, represent, and warrant that any and all information provided to each of the items related to this credentialing form and in connection with this credentialing process, is true, accurate, and complete. Failure to provide true, accurate, and complete information in this form may result in actions up to and including termination from all Magellan networks.

Signature of Authorized Pharmacy Representative (Required)	**Date**
Printed Name	**Title**