Form for Pharmacy Validation of Home Infusion Services

Summary: This form is for Pharmacies that participate in Prime Therapeutics (Prime) Medicare Part D Home Infusion (HI) Network. To maintain the integrity of the HI network, Prime requires participating Pharmacies to validate on an annual basis that they will continue to comply with these guidelines and/or requirements.

Validation: Please respond to the questions provided below. Sign this document validating that this Pharmacy currently participating in Prime's HI network will continue to meet the following requirements:

1.	Is the Pharmacy able to provide HI drugs for both short-term and long-term chronic care therapies to Covered Persons outside of a facility setting and bill through the member's Medicare Part D benefit plan?	○ Yes ○ No
2.	Is the Pharmacy accredited and/or licensed to be an HI provider?	○ Yes ○ No
3.	Is the Pharmacy able to provide a sterile environment?	○ Yes ○ No
4.	Is the Pharmacy able to provide HI drugs to Covered Persons in suitable dosage formulations for clinically appropriate administration?	○ Yes ○ No
5.	Is the Pharmacy (or another entity ensured by the Pharmacy, such as a home health agency) able to provide professional services and ancillary supplies to Covered Persons that include, but are not limited to tubing, syringes and infusion pumps?	○ Yes ○ No
6.	Is the Pharmacy able to provide HI drugs within 24 hours of a Covered Person's discharge from an acute care setting, unless the next required dose as prescribed is required to be administered later than 24 hours after discharge?	○ Yes ○ No
7.	Is the Pharmacy NPI registered with National Plan and Provider Enumeration System (NPPES) as a home infusion Pharmacy?	○ Yes ○ No
8.	If the Pharmacy administers vaccines, does it ensure that all pharmacists or other personnel administering vaccines are duly authorized under and abide by all applicable laws, regulations and guidelines, including, but not limited to those governing: • Certification requirements • Protocol • Education and training • Record generation and retention • Notification • Reporting requirements	○ Yes ○ No ○ N/A

My organization validates to Prime that this Pharmacy, currently participating in Prime's HI Network, meets the criteria as outlined above.

Organization name: _____ Submitter e-signature: _____

Submitter email: _____ Submitter title: _____

Submitter phone: _____ Submitter chain code: _____

Submitter NCPDP (if applicable): _____

Disclaimer: Failure to attest to this Form for Pharmacy Validation of Home Infusion Services or failure to meet the HI requirements may result in termination from Prime's HI Network.