



A **xerox** Company

## Home Infusion Therapy

### Addendum of Agreement to Alaska Medicaid Provider Enrollment Application (To be completed and signed by the pharmacist-in-charge)

#### Home Infusion Therapy enrollment requirements:

- (1) A completed Alaska Medical Assistance Program Enrollment form signed by the pharmacist-in-charge.
- (2) A Home Infusion Therapy Addendum to the enrollment agreement completed and signed by the pharmacist-in-charge.
- (3) Occupational License of pharmacist-in-charge issued under AS 08.80.
- (4) List of all contracted and employed registered nurses of the pharmacy.
- (5) Occupational licenses of all listed registered nurses if required under AS 08.

List of all contracted and employed registered nurses of the pharmacy (attach a list if more than six):

1. _____ Name	2. _____ Name	3. _____ Name
1. _____ Occupational License Number	2. _____ Occupational License Number	3. _____ Occupational License Number
4. _____ Name	5. _____ Name	6. _____ Name
4. _____ Occupational License Number	5. _____ Occupational License Number	6. _____ Occupational License Number

By my signature below, I understand and accept responsibility for this home infusion therapy pharmacy. I also acknowledge that this pharmacy is in compliance with all medical assistance federal and state statutes, regulations, including 12 AAC 52.400 – 12 AAC 52.440, policies, and procedures, and I agree that my responsibilities include:

- (1) compliance with all laws and regulations governing the activities of the pharmacy;
- (2) training of all pharmacy personnel;
- (3) establishing policies and procedures for pharmacy operations;
- (4) maintaining required records;
- (5) storage of all materials, including drugs and chemicals; and
- (6) establishing and maintaining effective controls against theft or diversion of prescription drugs.

That I will notify Affiliated Computer Services (ACS) *in writing within 30 days* upon occurrence of any of the following:

- (1) when I am no longer the pharmacist-in-charge,
- (2) when I have not complied with the requirement for responsibilities of the pharmacist-in-charge under 12 AAC 52.200 in any 30-day period, or
- (3) when there is a change in registered nurses of the pharmacy providing such services.

*I understand that my failure to provide such a notification to ACS constitutes an automatic breach of this agreement, making me automatically ineligible to receive Medicaid reimbursements as a home infusion therapy provider.*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Pharmacist-In-Charge/Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date