



## Contract Pharmacy Configuration Sign Off Form

<b>Entity Name:</b>	MANGUM REGIONAL MEDICAL CENTER
<b>OPAIID:</b>	CAH371330-00

Applicable Pharmacies					
Name	NPI	Claims Start Date * (Switch Fees of \$0.03 per claim start accruing)	Dispensing Fees	Pharmacy Payment Option	Manufacturer Exclusions (Eli Lilly, Sanofi, AstraZeneca, Merck, NovoNordisk, Boehringer Ingelheim, United Therapeutics, UCB, Amgen, Abbvie, Bristol Myers Squibb & Pfizer)
PUCKETT DISCOUNT PHARMACY	1821083809	6/1/2022	Third party: \$15.00 + 25% of the total reimbursement for brand drugs. Cash: \$15.00 flat fee brand and generic	Pharmacy pays Entity	Exclude United Therapeutics

Configurations			
	Yes	No	N/A
Exclude C2	X		
Exclude C3		X	
Exclude C4		X	
Exclude C5		X	
Apply PharmaForce's orphan drug list? (if applicable)	X		
For Profit (winners only)	X		

Look Back Period	
Full Time	365
Part Time	365
Referral	365

Medicaid Carve out				
Carve-Out Medicaid		Yes		
BIN#	PCN	Group	Reason	Start Date
010579	OKA01		Medicaid	1/1/2020
610084	DRTXPROD	MEDICAID	Medicaid	1/1/2020
610084	DRTXPROD	CSHCN	Medicaid	1/1/2020
610084	DRTXPROD	KHC	Medicaid	1/1/2020
610084	DRTXPRODKH	MEDICAID	Medicaid	1/1/2020
610084	DRTXPRODKH	CSHCN	Medicaid	1/1/2020
610084	DRTXPRODKH	KHC	Medicaid	1/1/2020
610517			Medicaid	1/1/2020
017606	P027017606	ARMEDICAID	Medicaid	1/1/2020

\*\* As of this date, fees will be incurred as \$0.03 per claim received from pharmacy. If PharmaForce needs to request historical claims data, the switch provider will charge entity an additional fee which will be quoted to entity

- It is ultimately the covered entity's responsibility to ensure accuracy and 340B program compliance. Please carefully review the information listed. Please let PharmaForce know if there are changes we should make to your account.
- It is the covered entity's responsibility to advise PharmaForce if you desire changes to any part of your 340B program, including fees, filters, prescriber panels, patient data, and/or Medicaid carve-in or carve-out classifications.
  - Entity agrees to pay contract PharmaForce fees as of claim start date."

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Signature

\_\_\_\_\_  
Date