# SPECIALTY PHARMACY CONSENT

1. This acknowledges that my physician has prescribed medication(s) for me and that **BioPlus Specialty Pharmacy Services, Inc.** and their network of pharmacies **MedScripts Medical Pharmacy, River Medical Pharmacy or Route 300 Medical Pharmacy** (each "**Pharmacy**") will serve as the medical pharmacy. The route of administration of this medication is indicated on the medication prescription label along with directions for use. I have voluntarily chosen to receive the medication and am of legal age and authorized to execute this consent form.

2. I understand that I have other pharmacy options available and that I have the right to choose my pharmacy provider. I acknowledge that my therapy is under the control of my physician; I select and authorize **Pharmacy** to furnish the medications and supplies deemed necessary to administer my therapy as ordered by my physician.

3. My physician has explained my therapy and treatment to me, alternate therapies available, and the substantial risks and hazards inherent with this therapy. I understand that there may be special instructions or training. I agree to read the instructions and complete any training necessary. I agree to abide by the instructions and training provided and will immediately alert the pharmacist and the prescribing physician of any medical conditions which may adversely impact my personal health or the effectiveness of the medication. I further understand that I have the opportunity to ask questions about the medication and all of my questions have been answered.

4. I understand all aspects of my home self-care and understand that I have the right to ask any questions and receive answers during my participation in the program. **I have been instructed to call "911" for emergency medical attention**.

5. I have received information regarding biomedical waste disposal, emergency preparedness and drug information.

6. I have received a copy of the Patient's Rights and Responsibilities and a copy of the Notice of Privacy Practices, and I understand these documents. I further know that any time I have questions, I can call the pharmacy at 1- 866-514-8082.
7. Because I am receiving specialty medications, **Pharmacy** is required by contract to obtain proof of delivery. I understand that I will be asked to sign for my delivery via the delivery carrier. If I am unable to sign for the delivery, I will sign and return the packing ticket enclosed with my shipment.

8. I authorize **Pharmacy** to bill my insurance provider. I understand that if no insurance coverage exists or if an insurer fails to pay, I may be financially responsible for the incurred charges.

9. Various drug manufacturers and other entities offer patient assistance programs that provide payment assistance, including without limitation co-pay cards, or cost reductions for certain therapies, prescriptions, and medications. As applicable, I authorize **Pharmacy** to take all necessary actions to enroll and register me in patient assistance programs for which I am qualified for the purposes of identifying and obtaining such payment support.

10. If you have insurance coverage provided through any type of state-, federal-, or government-funded programs, (Medicare, Medicaid, Federal Employees Health Benefits, TRICARE, VA), you are not eligible to participate in the Co-pay Program. I attest that my insurance plan is not a state or federal government insurance plan, such as Medicare, Medicaid, or Tricare.



**BioPlus Specialty Pharmacy** 376 Northlake Blvd., Altamonte Springs, FL 32701
**MedScripts Medical Pharmacy** 1325 Miller Rd. Suite K, Greenville, SC 29607
**River Medical Pharmacy** 4752 Research Drive, San Antonio, TX 78240
**Route 300 Pharmacy** 1208 Route 300 Suite 103, Newburgh, NY 12550
**BioPlus Specialty Pharmacy** 100 Southcenter Ct. Suite 100, Morrisville, NC 27560

11. If your prescription drug coverage is provided by a private commercial payer and the commercial payer has opted out of the Co-pay Program, you are not eligible to participate. I understand it is my responsibility to verify with my insurance plan any limitations they may have for the use of copay cards or other assistance I may use. I shall not accept any copay card or other assistance if prohibited by my insurance plan

12. Calls to the pharmacy may be recorded for training, record keeping and quality assurance purposes. Please contact the pharmacy at 1- 866-514-8082 with any questions regarding this form.

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT TO THERAPY.

| | |
|---|---|
| **Patient Name ("Patient"):** | |
| **Patient Signature:** | |
| **Former/Alias/Maiden Name (if applicable):** | |
| **Date of Birth:** | |
| **Date Signed:** | |
| **Name of Personal Representative (If Applicable):** | |
| **Signature of Personal Representative (If Applicable):** | |
| **Description of Personal Representative's Authority:** | |



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**IF YOU ARE ON INFUSION THERAPY PLEASE READ THE INFO BELOW**

1. **If I am an infusion patient,** I understand that there are additional risks associated with the use of intravenous medication and my physician has educated me about those risks. My physician has explained that there are risks, known and unknown, associated with the use of all medical equipment and supplies used with the administration of medication, and because I will be using the equipment and/or supplies at home, immediate emergency medical attention will probably not be available for any complication, injuries or adverse results that may occur in connection with using the equipment or supplies. **I have been instructed to call "911" for emergency medical attention**.

2. **If my therapy requires an electronic or mechanical pump,** it will be sent and indicated on my delivery ticket and will be accompanied by an operating instruction manual along with information about any applicable warranties.

3. I acknowledge that I have received information, such as an equipment warranty information form and/or a warranty information page in my operating instruction manual, about any warranties that may cover the pumps, devices, and other items supplied to me. Furthermore, the product is being sold or leased to me by **Pharmacy** as a service for my convenience. I understand that I am responsible for the replacement cost of lost, stolen and/or damaged equipment.

4. I understand further that any and all representations regarding the equipment are the responsibility of the manufacturer and its authorized agents (including, but not limited to distributors and authorized service technicians). I have received instructions on the operating and related minor maintenance of the equipment and have read the operating instructions all of which are, in my opinion, adequate to enable me to properly operate it without direction of professional support staff at **Pharmacy**.

I understand that, to the maximum extent permissible under law, **Pharmacy** shall not in any event be liable for any consequential damages, secondary charges, lawsuits, or damages resulting from an alleged defect of the equipment or disposable supplies. A home health nurse may operate this infusion device and I will follow his or her instructions.

If I am a Medicare beneficiary, I understand that **Pharmacy** honors all warranties expressed and implied under applicable State law and will not charge me or the Medicare program for the repair or replacement of Medicare covered items (including all purchased and capped rental items and other rented items) or services covered under warranty.

I understand that I may contact the pharmacy at 1- 866-514-8082 with any questions regarding this form

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT TO THERAPY.

| | |
|---|---|
| **Patient Name ("Patient"):** | |
| **Patient Signature:** | |
| **Former/Alias/Maiden Name (if applicable):** | |
| **Date of Birth:** | |
| **Date Signed:** | |
| **Name of Personal Representative (If Applicable):** | |
| **Signature of Personal Representative (If Applicable):** | |
| **Description of Personal Representative's Authority:** | |

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