Specialty Pharmacy Consent

1. This acknowledges that my physician has prescribed medication(s) for me and that **BioPlus Specialty Pharmacy Services, LLC and their network of pharmacies MedScripts Medical Pharmacy, River Medical Pharmacy, Route 300 Pharmacy, and Santa Barbara Specialty 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. I understand that if I have insurance coverage provided through any type of state-, federal-, or government-funded programs, (Medicare, Medicaid, Federal Employees Health Benefits, TRICARE, VA), that I am 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.

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.

13. I authorize BioPlus to communicate with me about my medication therapy by email, text message, or other digital communications. If I choose to opt out of communications for marketing or commercial purposes, I understand that BioPlus reserves the right to contact me about the preparation or delivery of my prescription medications.

Patient Name ("Patient"): _____
Patient Signature: _____
Former/Alias/Maiden Name (If applicable): _____
Date of Birth: _____
Date: _____
Name of Personal Representative (If applicable): _____
Signature of Personal Representative (If applicable): _____
Description of Personal Representative's Authority: _____