TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OUT-OF-STATE PHARMACY AGREEMENT
FOR THE TEXAS STATE HEALTH CARE PROGRAMS

This agreement will allow a pharmacy located more than 30 miles outside of Texas to dispense covered outpatient prescription medication(s) to a client of the Texas Medicaid Program, Children's Health Insurance Program (CHIP), Children with Special Health Needs (CSHCN) Services Program, or Kidney Health Care (KHC) Program (collectively referred to as the "Texas State Health Care Programs.") This is not an application for a traditional contract with the State of Texas (State) for above-referenced Texas programs. **The scope of this agreement is limited to the prescription(s) and eligible client(s) identified in the attachments to this agreement.**

* Is the pharmacy a Federally Qualified Health Center (FQHC) located on-site or off-site of FQHC? ☐ Yes ☐ No
HHSC's claims administrator reimburses FQHCs by a total encounter rate for all services under the Veterans Health Care Act of 1992. *Please refer to the following website for information regarding FQHC and the 340B Drug Pricing Program: http://www.hrsa.gov/opa/introduction.htm

STOP: If the response is "yes," the pharmacy does not qualify for reimbursement through this Agreement.

Date: ______________________ Pharmacy License Number: ______________________

Name of Pharmacy: ______________________

Physical Address: ______________________

City, State, Zip Code: ______________________

Pharmacy Mailing Address (if different from physical address):______________________

Pharmacy Contact Person: ______________________ Telephone Number: ______________________

Fax Number: ______________________ E-mail address: ______________________

Primary Taxonomy Code: ______________________ National Provider Identifier (NPI):______________________

Federal Employer's Identification Number: ______________________

This agreement is to provide outpatient prescription medication for the following program. Please place a check mark next to the applicable Texas State Health Care Program:

_____ Medicaid

__________ If Medicaid, were you referred by the Texas Migrant Care Network (yes/no).

_____Children's Health Insurance Program (CHIP)

_____ Children with Special Health Needs (CSHCN) Services Program

_____ Kidney Health Care (KHC) Program

For online submission:
Who is your software vendor: ______________________

Who is your switch company: ______________________
(The switch company is the vendor that receives and transfers claims from pharmacies to the Vendor Drug Program.)

For paper submission:
The pharmacy must complete and sign the Pharmacy Claims Billing Request (Form 3700) (available at txvendordrug.com).

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By signing this agreement, the Pharmacy agrees to the following:

1. The Pharmacy will submit claims for payment in the format identified below, and in accordance with the State's billing guidelines and procedures (see, e.g., Title 1, Texas Administrative Code, Part 15, Chapter 354, Subchapter F, and applicable provisions of the *Texas Pharmacy Provider Handbook* and *Pharmacy Provider Procedures Manual*).
2. The Pharmacy will comply with all applicable state and federal laws; and all laws, rules, regulations, policies and procedures relating to or governing the Texas Program identified above.
3. The Pharmacy certifies that the information submitted in and with this agreement is true, accurate, complete, and verifiable by source documents.
4. The Pharmacy will retain all pertinent records, including but not limited to prescription documents, medication invoices and medication acquisition documents for a minimum of five (5) years from the date of service. The "date of service" is defined as the date the pharmacy prepares, packages, compounds and/or labels the medication. If any litigation, audit, or other contract review process begins before the five (5) year period expires, the pharmacy will keep the records until all litigation, dispute resolution proceedings, audits, or reviews are resolved. Resolution has occurred when: there is a final decision in litigation; HHSC provides written notification that the audit, review, or dispute resolution proceeding is permanently resolved; or when HHSC and the pharmacy enter into a written agreement of resolution.
5. The Pharmacy will grant the State and federal government, and any of their agents, unrestricted access to the records described herein for purposes of auditing claims and/or identifying, investigating, sanctioning, or prosecuting fraud, abuse or waste.
6. In accordance with the requirements of Texas Government Code §2262.003, the Pharmacy understands and agrees that the acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The Pharmacy further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested.
7. The Pharmacy understands and agrees that the State cannot make payments directly to clients of the Texas State Health Care programs identified here. The pharmacy will not charge or pursue payment from a client of the Texas programs, or any person(s) financially responsible for the client, for anything other than a co-payment or cost-sharing amount specifically authorized by the State. For prescriptions dispensed to clients of the Texas Medicaid Program, the provider agrees to accept funds received from the State as payment in full.
8. This agreement is governed by the laws of the State of Texas and interpreted in accordance with Texas law. Proper venue for a claim arising from this agreement will be in a State District Court in Travis County, Texas.
9. Failure to comply with the requirements of this agreement may result in the cancellation or suspension of this agreement, and/or termination, suspension or recoupment of all or part of the payments made hereunder.

______________________________	______________________________
Signature of Pharmacist in Charge	Printed Name of Pharmacist in Charge
______________________________	______________________________
Signature of Pharmacy Owner	Printed Name of Pharmacy Owner
______________________________	______________________________
HHSC Only: Approved by	Printed Pharmacy Name

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Instructions for Submitting this Agreement

The agreement should be completed, signed, and faxed with the following information to:

Texas Health and Human Services Commission
Medicaid/CHIP Contract Management (H-330)
P.O. Box 85200
Austin, TX 78708-5200
Fax: 512-491-1974

Also include the following forms with the agreement:

1. A copy of your state pharmacy license.
2. A copy of the prescription signed by the physician.
3. A copy of the pharmacy's prescription label.
4. A copy of the Certification Regarding Debarment.
5. Form 74-176 (for direct deposit) (available at txvendordrug.com).
6. Form AP-152 (for Payee Identification Number) (available at txvendordrug.com).

For audit purposes, the State requests the following for each prescription filled by the out-of-state pharmacy regardless of online or paper submittal:

1. A copy of the prescription signed by the physician. If the prescribing physician is located outside Texas, please ensure the following information regarding the physician is noted either on the prescription or included as an additional attachment:
    - physician's name
    - state license number
    - National Provider Identifier (NPI)
    - business address (physical address including city and state)
    - county
    - telephone/fax number.
2. A copy of the pharmacy's prescription label.

Pharmacy providers and their software vendors should refer to the Texas Pharmacy Provider Procedure Manual (available at txvendordrug.com) for program requirements regarding system software, timely filing limits, monthly prescription limits, and allowable refills and quantities. Questions pertaining to claims processing and payment should be directed to the State's provider-only Pharmacy Resolution Help Desk at 1-800-435-4165.