



## Regional Cancer Care Associates Pharmacy | East Brunswick, NJ

We here at Regional Cancer Care Associates Pharmacy (“RCCA Pharmacy”) believe that disease states are managed best when a patient’s entire care team is engaged. We collaborate with your physician, insurer, and other healthcare providers in order to achieve the best possible outcome utilizing our Pharmacy Services. We help our patients manage their oncology therapies by:

- Providing expert clinical guidance and advice on your medications
- Providing specialty medication starter kits, sharps containers with instructions for use and educational material when applicable
- Aiding in the enrollment into copay assistance and financial support programs
- Medication compliance monitoring, detailed therapeutic progress reports in collaboration with your physician
- Providing nutritional and vitamin support
- Collaborating with your RCCA Physician to ensure complete therapeutic appropriateness and progress

### **MISSION STATEMENT:**

“Our goal at RCCA Pharmacy is to give the best possible care for our patients. We give the patient the best service possible and the best price available for the patient. “

You can visit us on the web to find out more about the services we provide, and how they may benefit you at: [www.rcca.com/pharmacy](http://www.rcca.com/pharmacy)

### **SERVICES ARE PROVIDED TO PATIENTS AT OUR EAST BRUNSWICK LOCATION:**

Brier Hill Court, K2 Building, East Brunswick, NJ 08816

**1-732-390- 0003** | 8 AM—4:30PM EST Monday – Friday (EST)

**1-844-683-6443** | Toll-free Afterhours Voicemail. Please contact your RCCA MD's office for any emergency if a RCCA Pharmacist is unavailable

#### **Please use the above listed contact information to:**

- Inquire about your current order status or any delays
- Report Adverse Reactions to medications or consult with our Pharmacists
- For more information about accessing medications in the event of an emergency
- Request information regarding disposal of medication
- Ask any questions regarding copayment assistance, your benefits and additional funding sources for your medication
- Request refills

#### **To help better serve you...**

- We will tell you how much you will save if the pharmacist dispenses a less expensive equivalent drug (if your doctor does not require the brand name). If you still want the brand name drug, the pharmacist will dispense that for you.
- We will let you know of your overall costs in writing if you choose to use RCCA pharmacy as an out-of-network pharmacy per your insurance carrier
- Your pharmacist will coordinate with your RCCA physician on any medication substitutions or substitution protocols, such as generic substitutions and therapeutic equivalents, and notify you verbally of any changes to the prescribed regimen.
- Please let your RCCA Pharmacy staff know at least 48 hours in advance of you needing your refill order.

### **SPECIAL CONSIDERATIONS FOR MEDICARE & MEDICAID PRESCRIPTIONS:**

You **have the right to request a coverage determination** from your Medicare/Medicaid drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an “exception”** if you believe:

1. You need a drug that is not on your drug plan’s list of covered drugs. The list of covered drugs is called a “formulary”.
2. A coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or.
3. You need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

#### **What you need to do:**

You or your prescriber can contact your Medicare/Medicaid drug plan to ask for a coverage determination by calling the plan’s toll-free phone number on the back of your plan membership card, or by going to your plan’s website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare/Medicaid drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

## PATIENT RIGHTS AND RESPONSIBILITIES

### YOU HAVE THE RIGHT TO:

1. Obtain relevant, accurate, current and understandable information from your RCCA Pharmacist concerning your treatment and/or drug therapy.
2. Discuss your specific drug therapy, the possible adverse side effects and drug interactions, and to receive effective counseling and education from your RCCA Pharmacist.
3. Expect that all prescribed medications you receive are accurately dosed, effective and in useable condition.
4. Choose the pharmacist and pharmacy provider where your prescriptions are filled and to not be pressured or coerced into transferring your prescriptions to another pharmacy or mail order service.
5. Confidentiality and privacy of all your patient counseling information contained in your patient record and all your Protected Health Information, as described in the RCCA Notice of Privacy Practices (NOPP).
6. Receive appropriate care without discrimination in accordance with physician orders.
7. Be advised if a medication has been recalled at the consumer level.
8. Call RCCA with any complaints about medication or privacy matters at (732)390-0003 and ask for the Pharmacy Manager, or contact us about them through our website [www.rcca.com/pharmacy](http://www.rcca.com/pharmacy) or contact the New Jersey Board of Pharmacy at (973)504-6450.
9. Voice your grievances/complaints regarding treatment or care or lack of respect or to recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal, and have your grievances/complaints investigated.
10. Be able to identify RCCA Pharmacy representatives through proper identification, including name, job title, and request to speak with a supervisor if requested
11. Choose a healthcare provider.
12. Receive information about the scope of care/services that are provided by RCCA Pharmacy directly or through contractual arrangements, as well as any limitations to RCCA Pharmacy's care/service capabilities.
13. Receive in advance of care/services being provided, complete oral and written explanations of charges for care, treatment, services and equipment, including the extent to which payment may be expected from Medicare, Medicaid, or any other third party payer, charges for which you may be responsible, and an explanation of all forms you are requested to sign.
14. Be informed of any financial benefits that might accrue when you are referred to an organization.
15. Be advised of any change in RCCA Pharmacy's plan of service before the change is made.
16. Receive information in a manner, format and/or language that you understand.
17. Have family members, as appropriate and as allowed by law, and with your authorization or the authorization of your personal representative, be involved in your care and treatment, and/or service decisions affecting you.
18. Be fully informed of your responsibilities.
19. Be informed about Generic or other substitutions to prescribed medications.
20. Be informed promptly of any manufacturer/FDA recalls affecting your prescribed medications.
21. If RCCA Pharmacy is found to be "out of network" resulting in higher costs to the patient, the patient will be notified of cost differential in writing prior to starting services
22. Be informed of patient assistance programs to assist with access to

medications.

23. Redirect your prescription if RCCA Pharmacy cannot source the medication
24. Decline participation, revoke consent, or disenroll from RCCA Pharmacy's patient management program at any point in time.
25. Be informed about the philosophy and the characteristics of RCCA Pharmacy's patient management program

### YOU HAVE THE RESPONSIBILITY TO:

1. Adhere to the plan of treatment or service established by your physician.
2. Participate in the development of an effective plan of care/treatment/services.
3. Provide, to the best of your knowledge, accurate and complete medical and personal information necessary to plan and provide care/services.
4. Ask questions about your care, treatment and/or services, or to have clarified any instructions provided by RCCA Pharmacy representatives.
5. Communicate any information, concerns and/or questions related to perceived risks in your services, and unexpected changes in your condition.
6. Notify RCCA Pharmacy if you are going to be unavailable for scheduled delivery times.
7. Treat RCCA Pharmacy personnel with respect and dignity without discrimination as to color, religion, sex, or national or ethnic origin.
8. Care for and safely use medications, supplies and/or equipment, according to instructions provided, for the purpose they were prescribed and only for/on the individual for whom they were prescribed.
9. RCCA Pharmacy should be notified of any changes in your physical condition, physician's prescription or insurance coverage. Notify RCCA Pharmacy immediately of any address or telephone changes whether temporary or permanent.
10. Pay all invoices upon receipt, and understand that unpaid accounts will be considered in default
11. Understand that RCCA Pharmacy acts solely as an agent for you in filling prescriptions through your insurance or other benefits assigned to RCCA Pharmacy; Understand that RCCA Pharmacy assumes no responsibility for assuring that benefits so assigned will be paid; and understand that your account will only be credited when RCCA Pharmacy actually receives payment.
12. Submit any forms that are necessary to participate in RCCA Pharmacy's patient management program, to the extent that is required by law.
13. Notify your treatment provider of participation in RCCA Pharmacy's patient management program.



**Notice of Privacy Practices, Patient Rights and Responsibilities**

Please sign below that you have received a copy of the Regional Cancer Care Associates Notice of Privacy Practices and Patient Rights and Responsibilities.

Patient Signature \_\_\_\_\_ Patient Name (Print) \_\_\_\_\_

Patient Representative Name (Print) \_\_\_\_\_

Patient Representative (Signature) \_\_\_\_\_

Date \_\_\_\_\_

(To rescind any of the above information, please notify RCCA Pharmacy immediately)

(\*\*You may refuse to sign this acknowledgement\*\*)

**Please fill out and return this form to RCCA Pharmacy in the enclosed envelope.**



## Regional Cancer Care Associates Pharmacy | East Brunswick, NJ

I hereby authorize Regional Cancer Care Associates LLC and their employees, agents and contractors (collectively "RCCA Pharmacy"), to use or disclose, as specified in this Authorization, my "protected health information" that is covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"). I understand that "protected health information" includes records disclosed to RCCA Pharmacy by health care providers and facilities that previously provided treatment to the Patient. I also understand that "protected health information" may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment or related communications, or information relating to testing or treatment for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)). I specifically request and authorize release of information in my records regarding HIV and/or AIDS, if such information is contained in my records.

**Information to be Used or Disclosed:**

Complete records, including all prescriptions and billing records **OR**  The following selected items (Please Specify below)

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Person(s) Authorized to Make the Use or Disclosure:**

The following persons or class of persons are authorized to make the specified disclosures of my protected health information:

All RCCA Pharmacy staff, including pharmacists, technicians, navigators, and clinical staff. **OR**  (Please Specify) Only the following persons:

**Recipient(s) of Use or Disclosure:**

\_\_\_\_\_

My protected health information may be disclosed to the following persons or class of persons:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ / Name: \_\_\_\_\_ Relationship \_\_\_\_\_

**Purpose(s) of the Disclosures:**

Inability or unavailability to respond to RCCA-specific questions and services **OR**  (Please Specify): \_\_\_\_\_

**OR**

I am requesting the disclosure of my protected health information pursuant to this Authorization, and the information will be used and disclosed at my request.

**Expiration**

This Authorization will expire on the following date or event \_\_\_\_\_.

**Revocation**

I understand that I may revoke this Authorization by submitting a written revocation to the Pharmacy Manager of the RCCA Pharmacy location which serves me, provided that such revocation shall not be effective with respect to any use or disclosure made by RCCA Pharmacy in reliance on this Authorization prior to the date of RCCA Pharmacy's receipt of my revocation.

I understand that RCCA Pharmacy cannot require me to sign this Authorization in order receive treatment unless the provision of health care by RCCA Pharmacy is solely for the purpose of creating protected health information for disclosure to a third party or for research-related treatment, in which situations RCCA Pharmacy will not provide the service unless I sign this Authorization.

I understand that the information used or disclosed by RCCA Pharmacy pursuant to this Authorization may be subject to re-disclosure by the recipient in which case it might no longer be protected under the HIPAA Privacy Rule. However, I understand that in some cases, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize RCCA Pharmacy to copy this Authorization and to send the recipient the re-disclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether or not my records contain information protected by those laws.

**[Applicable if Authorizations Requested by RCCA Pharmacy]**

I understand that if this Authorization is being requested by RCCA Pharmacy, RCCA Pharmacy must provide me with a copy of the Signed Authorization.

I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person authorized to permit release of records on Patient's behalf. I hereby release RCCA Pharmacy (as defined above) from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

Print Name \_\_\_\_\_ Date \_\_\_\_\_ Patient Signature \_\_\_\_\_

**OR** Signature of Patient's Authorized Representative \_\_\_\_\_ Patient Representative Name (Print) \_\_\_\_\_

Basis of authority to sign for patient: \_\_\_\_\_