

INSTRUCTIONS FOR COMPLETING THE “ONLINE CONTRACT PHARMACY REGISTRATION FORM” FOR THE 340B DRUG PRICING PROGRAM

Covered entities that plan to utilize contract pharmacy arrangements to dispense drugs purchased under the 340B Drug Pricing Program must register the arrangements online and submit the **Online Contract Pharmacy Registration Form that is generated at the end of the online process** to the Office of Pharmacy Affairs (OPA) for each contract. **This registration form must be completed and submitted according to the established deadlines that are published on the OPA website (www.hrsa.gov/opa).**

OPA only accepts online contract pharmacy registrations at <http://opanel.hrsa.gov/opal/default.aspx>.

IMPORTANT NOTE: The Registration Process must be started and completed within the same browser session. Incomplete Registration Forms cannot be saved for later submission. It is imperative that pharmacy names and addresses are added accurately during the registration process to avoid lengthy delays in 340B implementation.

Prior to registering a contract pharmacy online, a covered entity must have their own legal counsel review all contracts or other legal documents to ensure that all Federal, State and local requirements have been met. OPA will not review contracts. The agreement between the covered entity and the contract pharmacy must be fully executed and include those elements outlined in the Contract Pharmacy Services Guidelines (<http://edocket.access.gpo.gov/2010/pdf/2010-4755.pdf>).

START DATE – Contract Pharmacy start date is set at the time OPA approves the contract pharmacy arrangement or at a later date if requested. The contract pharmacy arrangement should not begin prior to the start date shown on the OPA database. OPA will **NOT** post a retroactive start date (<http://opanel.hrsa.gov/opa/CP/CPExtract.aspx>). The contract pharmacy start date may not precede the registration date of the covered entity. **For example, an organization added as a covered entity for the April 1, 2012 quarter may not have a contract pharmacy start date prior to April 1, 2012.**

Online Contract Pharmacy Registration Form - This form must be completed and signed by both parties involved in a contract pharmacy arrangement. The Registration Form must be signed for each contract and must be submitted with the addenda or relevant addendum. By submitting this registration form to OPA, the covered entity and contract pharmacy certify that a written contract is in effect between both parties. It is NOT acceptable to register a contract pharmacy if contract terms are still under negotiations and/or not fully executed.

SIGNATURES – The Registration Form must be signed by the covered entity’s Authorizing Official. For the pharmacy, the responsible representative may be the owner, the president, chief executive officer, etc. If you are in doubt regarding the acceptability of a signature, please contact OPA prior to submitting the form. **Please note that OPA does not have the capability of receiving electronic signatures at this time and will begin processing the online submissions of the Contract Pharmacy Registration Form only after receiving a copy or the original with the required signatures.**

SUBMISSION PROCESS – Once you have registered a contract pharmacy online, the responsible parties must sign the Online Contract Pharmacy Registration form that is generated at the end of online process. OPA offers multiple options for submitting the Registration Form:

1. Email: Scan the form and email it to 340Bcontractpharmacy@hrsa.gov .
2. Fax: Covered entities may fax the forms to OPA at 301-594-4982 before mailing the originals.
3. Mail: Covered entities must mail originals to Office of Pharmacy Affairs, 5600 Fishers Lane, Room 10C-03, Rockville, MD 20857.
4. Data Upload: To register more than 20 covered entity- contract pharmacy arrangements, covered entities may request a data upload by e-mailing 340Bcontractpharmacy@hrsa.gov .

Submit the signed Contract Pharmacy Registration forms to OPA within 15 days from the time the online registration was completed. If the fully signed registration form is not received within this time period, the contract pharmacy registration will be deleted from the system and the registration process must be started over again. **The Contract Pharmacy Registration process is not complete unless the form has been completed in its entirety and the original, signed copy is received by OPA.** Email notifications will be sent once the registration has been processed.

pharmacy, the responsible representative may be the owner, the President, Chief Executive Officer, Chief Operating Officer, or Chief Financial Officer. If you are in doubt regarding the acceptability of a signature, please contact the Pharmacy Services Support Center at 1-800-628-6297 or via email at pssc@aphanet.org prior to submission of your registration form.

NOTE ON EFFECTIVE DATE - Do not begin the contract pharmacy arrangement prior to the effective date shown on the OPA web-based database. Please be advised OPA will NOT post a retroactive date. (<http://opanel.hrsa.gov/opa/CPSearch.aspx>). Please submit the Signed Contract Pharmacy Registration form to OPA at least ten business days before the effective date of the contract. OPA attempts to post forms received in this timeframe by the contract's effective date. Please also note the contract pharmacy effective date may not precede the registration date of the covered entity. For example, an organization added as a covered entity for the April 1, 2010 quarter may not have a contract pharmacy effective date prior to April 1, 2010.

THE FOLLOWING INFORMATION IS REQUIRED TO COMPLETE THE REGISTRATION FORM. PLEASE REVIEW THE INFORMATION CAREFULLY BEFORE SUBMITTING THE FORM.

Pre-Qualification Questions

IMPORTANT: Prior to registering a Contract Pharmacy for the 340B Program, there should be a Covered Entity registered and approved by OPA. If the Covered Entity is not approved in the 340B system, you are unable to complete the Registration form and will be returned to the HRSA Homepage.

- 1. Is the Covered Entity already approved in the 340B Program? Yes No

- 2. Do you know the 340B ID number? Yes No

- 3. Do you know the Pharmacy zip code? Yes No

- 4. Have the legal documents been reviewed and the written contract fully executed? Note: Prior to completing this form, a Covered Entity must have their own legal counsel review all contracts or other legal documents to ensure that all Federal, State, and local requirements have been met. Yes No

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Search Criteria

340B ID: CH051050

Search Clear

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Search Results:

The number of rows returned: 1 Rows/Page: 10 ▼ Set Show Search Criteria

	340B ID	Entity Type	Entity Name	Sub Name	Address	City	State	Start Date	Term Date	Edit Date
<input type="radio"/>	CH051050	CH	CHICAGO FAMILY HEALTH CENTER		9119 SOUTH EXCHANGE AVENUE	CHICAGO	IL	01/01/1998		12/19/2011

1

Continue Cancel

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Active Contract for CH051050 - Consolidated Health Center Program

Please review the list of active Contract Pharmacies. If you want to request a Contract Pharmacy termination, select the appropriate contract(s) and requested termination date(s). If all Contract Pharmacies are valid, select the appropriate option to continue adding the contract.

Note: Submitting a request to terminate contracts sends an email notification to the Office of Pharmacy Affairs to review the request. It does not automatically terminate the Contract Pharmacy in the 340B application.

Request Contract Pharmacy termination(s) then continue adding a Contract Pharmacy Arrangement.


I do not want to submit any request for Contract Pharmacy termination(s) at this time. Continue adding Contract Pharmacy Arrangement.

Active Contracts

Request to Terminate	Pharmacy Name	City	State	Start Date	Requested Termination Date
<input type="checkbox"/>	Walgreens # 10350	CHICAGO	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 10485	CALUMET PARK	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 13106	CHICAGO	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 147	CHICAGO	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 162	CHICAGO	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 2210	CHICAGO	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 2300	CHICAGO	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 2387	CHICAGO	IL	03/16/2012	<input type="text"/> 
<input type="checkbox"/>	Walgreens # 3539	CHICAGO	IL	03/16/2012	<input type="text"/> 

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	340B ID	Entity Type	Entity Name	Sub Name	Address	City	State	Start Date	Term Date	Edit Date
<input checked="" type="radio"/>	CH051050	CH	CHICAGO FAMILY HEALTH CENTER		9119 SOUTH EXCHANGE AVENUE	CHICAGO	IL	1/1/1998		12/19/2011

Search Criteria

Pharmacy Zip:

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	340B ID	Entity Type	Entity Name	Sub Name	Address	City	State	Start Date	Term Date	Edit Date
<input checked="" type="radio"/>	CH051050	CH	CHICAGO FAMILY HEALTH CENTER		9119 SOUTH EXCHANGE AVENUE	CHICAGO	IL	1/1/1998		12/19/2011

Search Results

The number of rows returned: 14 Rows/Page:

	Pharmacy Name	Address	City	State	Zip
<input type="radio"/>	WALGREENS #2387	1616 E 87TH STREET	CHICAGO	IL	60617
<input type="radio"/>	WALGREENS #5192	2924 E 92ND ST	CHICAGO	IL	60617
<input type="radio"/>	WALGREENS #6238	2011 E 95TH STREET	CHICAGO	IL	60617
<input type="radio"/>	Walgreens #88002	4400 Highway #19	Windsor	WI	60617
<input type="radio"/>	The requested Pharmacy is not in this list. A new Pharmacy needs to be created.				

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Contract Details

*Requested Contract Begin Date: 8/1/2012

This date must be equal to or greater than the Covered Entity Start Date and cannot be less than the current date. NOTE: Allow 10 to 15 business days for approval. Approval time may be longer dependant on workload and registration discrepancies. The Contract Pharmacy arrangement is not valid until it has been approved by OPA.

Covered Entity Details

340B ID: CH051050
Entity Name: CHICAGO FAMILY HEALTH CENTER
Entity Sub-Division Name:
Entity Type: CH
Grant/Provider Number: H90CS00514
StartDate: 1/1/1998
Address: 9119 SOUTH EXCHANGE AVENUE
CHICAGO, IL 60617

Contract Pharmacy Details

[Continue](#) [Undo](#)

*Name: _____
*Address Line 1: _____
Address Line 2: _____
*City: _____
*State: Select a State
*Zip: _____ - _____

CE Signing Official

*Name: _____
*Title: _____
*Phone: _____ Ext: _____
*Email: _____
*Signed By Date: _____

CP Signing Official

*Name: _____
*Title: _____
*Phone: _____ Ext: _____
*Email: _____
*Signed By Date: _____

CE Primary Contact

Make Contact Information same as Signed by Information

*Name: _____
*Title: _____
*Phone: _____ Ext: _____
*Email: _____

CP Primary Contact

Make Contact Information same as Signed by Information

*Name: _____
*Title: _____
*Phone: _____ Ext: _____
*Email: _____

*Please answer one of the following, which is required.

Do you want to add another contract?
 No
 Yes, for same Contract Pharmacy.
 Yes, for same Covered Entity.


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Register Pharmacy Online

Form successfully submitted. To complete the registration process, an original, signed form must be submitted and received by the office of Pharmacy Affairs, 5800 Fishers Lane, Mail Stop 10C-03, Rockville, MD 20857 or Fax (301) 594-4982. It is NOT necessary to send this document via express mail. You can also email a copy of signed, scanned form to 340bcontractpharmacy@HRSA.gov

Contract Pharmacy Details

Contract Pharmacy Name: test	Address: test
City: yesy	State: IL

Covered Entity Details

Covered Entity Name: CHICAGO FAMILY HEALTH CENTER	Covered Entity Type: Consolidated Health Center Program
Covered Entity Sub-Division Name:	Grant/Provider Number: H80CS00514
Contract Begin Date: 6/1/2012	

Your Registration Form has been submitted.

Please keep in mind that by adding multiple contracts in one process, the Registration form generated by the system will condense the signature page to include one instance of the signature for the reused Covered Entity or Pharmacy and individual signatures for each contract for the other contract representatives. This may not be the desired behavior if, for example, there are multiple interested parties signing on behalf of various contract pharmacies. To generate unique signature documents for each contract, select the option to complete the process after each contract is submitted.

Print
Done



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Online Contract Pharmacy Registration Form for the 340B Program

This is to certify that effective _____ a Contract Pharmacy Services arrangement is in effect between:

340B ID Number:

Covered Entity Name:

Street Address:

City, State, Zip:

and

Pharmacy Name:

Street Address:

City, State, Zip:

The undersigned represents and confirms that he/she is fully authorized to bind the Covered Entity or the Pharmacy listed, and certifies that the contents of any statement made or reflected in this document are truthful and accurate. The Covered Entity and the Pharmacy will comply with all of the requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines, including, but not limited to, the prohibitions on duplicate discounts/rebates, and drug diversion. The Covered Entity and the Pharmacy agree to be in compliance with the provisions of the Contract Pharmacy Services Guidelines as set forth in the *Federal Register*, at 75 Fed. Reg. 10272 (March 5, 2010), which can be found at <http://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf>. The authorizing official certifies on behalf of the covered entity that the contract pharmacy arrangement will be performed in accordance with OPA requirements and guidelines including, but not limited to, that the Covered Entity obtains sufficient information from the contractor to ensure compliance with applicable policy and legal requirements, and the Covered entity has utilized an appropriate methodology to ensure compliance (e.g., through an independent audit or other mechanism). The Covered Entity has, and continues to bear, full responsibility and accountability for compliance with all 340B requirements, including but not limited to any 340B violations by the Contract Pharmacy. The Covered Entity agrees to notify the Office of Pharmacy Affairs, in writing, of any material changes in the contract arrangement and/or material breach by the covered entity of any of the foregoing.

Signature of Authorizing Official of Covered Entity

Date

(Type or Print Name and Title)

Signature of Responsible Representative of Pharmacy

Date

(Type or Print Name and Title)