

EPIC Pharmacies, Inc.
PRE-MEMBERSHIP FORM
This is not an application.



EPIC Pharmacies, Inc.

Form B3

For Internal Use Only	
Executive Approval: _____	Date: _____
Stock # _____	Non-Stock _____
Referred By: _____	
EPIC Pharmacies Account #: _____	

Today's Date: _____

Pharmacy Corporate Name: _____

DBA or T/A (Please circle one if applicable): _____

Pharmacy Street Address: _____

City, State & Zip Code _____ County _____

Mailing Address (If different from street address): _____

Telephone: _____

Fax: _____

E-Mail: _____

Web Site Address: _____

Pharmacy Manager or Main Contact name: _____

Name of Owner: _____

% of Ownership: _____ %

Name of Owner: _____

% of Ownership: _____ %

Head Pharmacist, if not owner: _____

Pharmacist License #: _____

% of Pharmacy Pharmacist owned: _____ %

of employees (excluding owner): FT _____ PT _____

Referred to EPIC Pharmacies by: _____

Square Footage of Pharmacy: _____

Location (Please check one):
City _____
Rural Area _____
Suburb _____

Legislative District: _____

**If any of the below number(s) are missing pharmacy will remain pending until all numbers are received by this office.*

*Federal Tax I.D. #: _____

*NCPDP# (NABP#): _____

*NPI # _____

*Pharmacy License#: _____

*DEA#: _____

Are you currently with another buying group?
Yes _____ No _____
If yes, please give current buying group name: _____

Has your Pharmacy License ever been revoked or suspended? Yes _____ No _____
If yes, please give explanation: _____

Number of years this Pharmacy has been in business with present owner(s) _____
If new Pharmacy, opening date: _____
If Pharmacy is a current EPIC Pharmacy with change of ownership, New Owner Effective Date: _____

Additional Pharmacies Owned? (Please check one)
Yes _____ No _____
If yes, list names: _____

Name Closest EPIC Pharmacy: _____

Pharmacy Name _____

Miles from your Pharmacy _____

PHARMACY INFORMATION

(Please check/circle all that apply):

BUSINESS: Corporation _____
Sole Proprietor _____
Partnership _____
LLC _____
Other _____

TYPE: Close Door (LTC) _____
Retail (Apothecary) _____
Retail (Traditional) _____

DELIVERY: Yes / No

DRIVE THRU: Yes / No

DROP BOX: Yes / No

SPECIALTY: Compound _____
DME _____
Medicare Billing _____

PHARMACY AUTOMATION: ScriptPro _____
Innovation Robot _____
Automated Fastfill _____
Parata _____
Baker Cells & Cassettes _____

MEDICARE ACCREDITATION: Registered _____
Accreditation Complete _____
Do you utilize NASI? _____
Yes / No

HEALTH INSURANCE: Do you offer Health Insurance to your employees? _____
Yes / No
If yes please list plan: _____

MISCELLANEOUS VENDOR *(List name of vendor):*

Bags/Labels: _____

Greeting Cards: _____

Credit Card Processor: _____

Diabetic Strips/Meters: _____

Vitamins: _____

Vials: _____

Return Company: _____

Other: _____

WHOLESALER & GENERIC DRUGS INFO:

Wholesaler(s) Monthly Volume: _____

Primary Wholesaler – Name: _____

Account # _____ Vol. _____ K per month

Utilizing Wholesaler Private Label: Yes / No

Secondary Wholesaler – Name: _____

Account # _____ Vol. _____ K per month

Other Wholesaler – Name: _____

Account # _____ Vol. _____ K per month

ANDA/VIP Generics: _____

Account # _____ Vol. _____ K per month

BUYING GROUP AFFILIATION & CREDIT AUTHORIZATION:

We hereby authorize you (primary wholesaler or other vendor) to release to EPIC Pharmacies, Inc. any and all information necessary to process the forgoing Application for Participation and/or Subscription Agreement.

We hereby elect EPIC Pharmacies to be our Buying Group as of the approval date of this pre-membership form. Changing your Buying Group affiliation may affect your eligibility for programs and rebates you are receiving from your current Buying Group.

A photographic or carbon copy of this Authorization, being a valid copy of the signature(s) of the undersigned, may be deemed to be as valid as the original.

(Pharmacy Name)

(Date)

(Signature)

(Print Name)

For Internal Use Only
_____ (Approval Date)



A Network of Independently Owned Pharmacies
Attachment A

License Verifications

Date: ___/___/___

Pharmacy License Verification:

Pharmacy Name: _____

Address: _____ City: _____ State: _____ Zip: _____

License #: _____

Valid Thru Date: ___/___/___

Past Violations/Revocations (Y/N): _____

If yes, date ___/___/___ Explanation: _____

Any Pending Violations/Revocations (Y/N): _____

If yes, date ___/___/___ Explanation: _____

Pharmacist License Verification:

Pharmacist Name: _____

License #: _____

Valid Thru Date: ___/___/___

Past Violations/Revocations (Y/N): _____

If yes, date ___/___/___ Explanation: _____

Any Pending Violations/Revocations (Y/N): _____

If yes, date ___/___/___ Explanation: _____

Signature: _____

Attachment B

Form W-9
 (Rev. October 2007)
 Department of the Treasury
 Internal Revenue Service

**Request for Taxpayer
 Identification Number and Certification**

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number : : :
OR
Employer identification number : : :

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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A Network of Independently
Owned Pharmacies

Own Use Provision:

EPIC member acknowledges that any and all Products purchased under the EPIC Preferred™ contract, directly or indirectly, are for member’s “own use” and products purchased hereunder may not be commercially resold to any other entity or person.

EPIC members will purchase products only for the normal and customary use of such products for the provision of health care services by the participant, and not for resale or distribution to third parties.

Member’s who refuse to agree to the contract term that the products purchased are for participant’s own use, are ineligible to purchase the products under this contract.

If a member is identified as reselling or distributing EPIC Preferred™ contract items to third parties, EPIC Pharmacies will be entitled to damages from the member including but not limited to the amount of administrative fees paid during the term of this agreement, and for charge-backs incurred on products purchased through any approved EPIC vendor.

Data Access Provision:

I hereby authorize any of the vendors or suppliers that I utilize, that is an EPIC approved vendor, to forward to the EPIC Pharmacies corporate office my purchase detail (down to the invoice level) on a schedule as required by the EPIC office.

EPIC Preferred™ Purchasing Agreement:

This EPIC Preferred™ agreement is a statement of acceptance of the purchasing contracts offered by EPIC Pharmacies, Inc. as the primary agreement for purchasing contract products by the undersigned pharmacy. This agreement represents acceptance of the feature known as **automatic-substitution** whereby it applies to purchasing pharmaceuticals through EPIC Pharmacies. By signing this agreement, an EPIC member is tied exclusively to this agreement for the purposes of compliance to the EPIC Preferred™ contract and all contracts administered through the EPIC’s prime vendors and authorizes EPIC to load my pharmacy to the EPIC Preferred™ auto-substitution program.

By signing and submitting this agreement, the undersigned is authorizing EPIC’s prime vendor to place me on the EPIC Preferred™ program, removing me from any existing buying group contracts or buying group(s) affiliation.

Not signing this agreement will mean forfeiture of all benefits associated with the EPIC Preferred contract administration fees, rebates and volume incentives. Member will have access to contract pricing only.

Note: Please remove my store from any existing buying group affiliations and add my store exclusively to EPIC Pharmacies, Inc. Retail Group Purchasing Organization.

Pharmacy Name

DEA #

Authorized By (name)

Signature

Title

Date

Please fax to 410-667-3786



A Network of Independently
Owned Pharmacies

FCC Fax Regulation: Stringent Ruling Requires Your Authorization

On July 3, 2003, the Federal Communications Commission (FCC) issued a Report and Order amending the regulations that implement the federal Telephone Consumer Protection Act of 1991 (TCPA). The regulations were published in the Federal Register and will take effect on January 1, 2005. Most of the attention directed to this high-profile ruling was aimed at the do-not-call list, which generally does not impact trade and professional associations. However, the FCC made significant changes to the rules governing unsolicited faxes, which will have a direct and substantial impact on associations and all businesses that engage in marketing by fax.

What This Means to You

The new regulations will make it illegal for EPIC Pharmacies, Inc. ("EPIC") to send our members all fax communications that you are accustomed to receiving including but not limited to: industry news, cost savings announcements, vendor sales offers, invoices, monthly statements and other EPIC program developments without first obtaining the recipient's signed, written consent. Essentially, this would significantly restrict our ability to communicate via fax with our members.

All of our methods by way of mail, fax, email and phone communications, to our membership are a vital means to pass on important program updates that you are accustomed to receiving from the organization. It is imperative that these communication tools are readily available to keep our membership informed.

Action Required

The new rules mandate signed, written consent in order to send any fax that contains an "unsolicited advertisement" ("unsolicited advertisement" has an extraordinarily broad definition according to the FCC) to anyone, including our members. Please complete the consent form below and return to EPIC by fax at 1-410-667-3786. We ask that you return this form immediately. **Please remember to sign the form.**

I understand that by signing below, I consent to receive phone, fax and email communications sent by or on behalf of EPIC Pharmacies, Inc., a Maryland corporation.

Pharmacy Name: _____

Address: _____

City/State/Zip: _____

Email: _____

Phone: _____ Fax: _____

Printed Name: _____ Title (if applicable): _____

Signature: _____ Date: _____

rev 02/11



EPIC Pharmacies



Buying Group Members

<http://www.fpn.org>

- American Pharmacies
- American Pharmacy Services Corp.
- Associated Pharmacies, Inc.
- Association of Northwest Pharmacies
- EPIC Pharmacies
- Independent Pharmacy Alliance, Inc.
- Independent Pharmacy Buying Group, Inc.
- Independent Pharmacy Cooperative
- Keystone Pharmacy Purchasing Alliance, Inc.
- Pace Alliance, Inc.
- Partners in Pharmacy Cooperative
- Pharmacy Franchise Owners Association
- Pharmacy Group of New England
- Pharmacy Provider Services Corp.
- Pharmacy Providers of Oklahoma, Inc.
- Pharmacy Services Inc.
- Quality Care Pharmacies
- RxPlus Pharmacies, Inc.
- Southern Pharmacy Cooperative
- TrueCare Pharmacy
- United Drugs
- United Pharmacists Network, Inc.

Buying Group Affiliation Form

EPIC Pharmacies, (EPIC), is a member of the Federation of Pharmacy Networks (FPN), a national organization of independent pharmacy buying groups. **EPIC** participates in some FPN contracts and collects rebates and/or administrative fees based upon **EPIC's** member participation. Your store is listed as a member of two different FPN buying groups: **EPIC** and _____ . Manufacturers, for rebate purposes, will allow only one buying group affiliation.

Note: Changing your Buying Group affiliation may affect your eligibility for programs and rebates you are receiving from your current Buying Group.

+ Please make **EPIC** my FPN buying group affiliation of record.

(Signature) _____ (Date) _____

PLEASE PRINT:

Pharmacy Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

DEA#: _____ NABP: _____ NPI: _____

Wholesaler Name: _____ Account#: _____

***Please complete this form and fax it to the EPIC Office.
FAX: 410-667-3786***



A Network of Independently
Owned Pharmacies

Autoship Authorization

EPIC Pharmacies has developed a network of stores that participate in an **EPIC approved generic product auto-ship program**. From time to time EPIC is presented with an opportunity to auto-ship generic products to our members from one of our approved suppliers at **significant savings**. With AMP on the horizon we need to be more aggressive in obtaining high volume generics at substantial savings. We'd like your permission to send products to your pharmacy.

Overview:

- All products will be shipped from an approved EPIC supplier.
- EPIC will be extremely selective in the products we agree to ship. Products will always be in the top tier of products purchased collectively by our members.
- A one time shipment having a minimum of 40% net savings over the current industry average price.
- The products will have at least 9 months dating remaining.
- EPIC will limit the shipped quantities to one month average purchase volume. This is based upon products purchased collectively by our members, from all approved sources, in an average month as we have access to all purchase data.
- The supplier will invoice your store at the everyday retail price. Your monthly rebate check from EPIC will include the additional rebate associated with this product. As always, our office will be auditing the rebates to ensure accuracy.
- Reorders of the products with the rebate may be available for a limited time.
- By electing to participate you agree that the products are non-returnable.

We have discussed on a number of occasions the need for EPIC to purchase product as efficiently as possible to ensure our overall profitability. So as we are presented opportunities like this, we will work to maximize the benefit for us all.

Please check one box:

ACCEPT

DECLINE

Pharmacy Name

DEA #

Authorized By (Print)

Date

Signature

rev 02/11



Dear Independent Pharmacist:

Once your pharmacy joins the EPIC Pharmacies, Inc. buying cooperative, the pharmacy can apply for participation in EPIC Pharmacy Network (EPN). EPN provides many third party network services, including contracting with third party payers and a centralized helpdesk to save you time and money. In addition, EPN offers electronic claims reconciliation and accounts receivable services through its **REGULATOR™** program.

Please find enclosed documentation that summarizes the services provided by EPN and **REGULATOR™**. **After reviewing this information, if you would like to be contacted with more details on these services, simply fill out the form below and return it with your EPIC Pharmacies Pre-Membership Form.**

We look forward to the opportunity to further discuss these exciting programs with you.

Sincerely,

Patrick M. Berryman
Executive V.P. Managed Care Services

+++++

PLEASE PRINT ALL INFORMATION:

Contact Name: _____

Pharmacy Name: _____

Mailing Address: _____

City, State ZIP: _____

Phone: _____

NCPDP/NABP#: _____