We here at Solera Specialty 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 Specialty Pharmacy Services. We help our patients manage their various 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

Our Mission Statement

"To deliver superior & cost-effective specialty pharmacy fulfillment, patient-centric clinical management and adjunct services that result in optimal patient outcomes in a highly ethical and enriching environment for our associates."

You can visit us on the web to find out more about the services we provide, and how they may benefit you at: www.SoleraRx.com

Services are provided to patients at our Pompano Beach location: 2100 Park Central Blvd N #300, Pompano Beach FL 33064

(954) 615-1840 **9 AM-5PM** Monday - Friday (EST) **(877)-712-7864** **24/7 Hotline** Toll-free Afterhours & Emergency Contact

Please use the above listed contact information to:

- Inquire about your current order status or any delays
- Request refills (please give 7 days for refill requests)
- 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

In an attempt to limit paper waste and help conserve the environment, Solera Specialty Pharmacy has the following information available on our website. Please visit www.SoleraRx.com/NewPatients to complete these forms:

- Patient Rights and Responsibilities acknowledgement
- Health Information Authorization Form

****If you prefer paper copies, please contact 877-712-7864 and ask for a "New Patient Enrollment Package".**

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.

solera
SPECIALTY PHARMACY®

YOU HAVE THE RIGHT TO:

1. Obtain relevant, accurate, current and understandable information from your Solera Pharmacist concerning your treatment and/or drug therapy
2. Discuss your specific drug therapy, the possible adverse drug side effects and drug interactions, and to receive effective counseling and education from your Solera 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 Solera Notice of Privacy Practices (NOPP).
6. Receive appropriate care without discrimination in accordance with physician orders
7. Call Solera with any complaints about medication or privacy matters at 954-615-1840 and ask for the Pharmacy Manager, or contact us about them through our website, **www.SoleraRx.com** or contact FL Board of Pharmacy at 850-488-0595 or floridaspharmacy.gov/contact
8. Solera's email at Pharmacy@solerarx.com is available to send any requests. Solera personnel will respond within 1 to 3 business days to all email requests
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 Solera representatives through proper identification.
11. Choose a healthcare provider.
12. Receive information about the scope of care/services that are provided by Solera directly or through contractual arrangements, as well as any limitations to Solera'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 Solera'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. Decline participation, revoke consent, or disenroll from Solera's patient management program at any point in time.
19. Be informed about the philosophy and the characteristics of Solera's patient management program.
20. Be fully informed of your responsibilities.
21. Be informed about Generic or other substitutions to prescribed medications.
22. Be informed promptly of any manufacturer/FDA recalls affecting your prescribed medications.
23. If Solera is found to be "out of network" resulting in higher costs to the patient, the patient will notified of cost differential prior to starting services
24. Be informed of patience assistance programs to assist with access to medications
25. Redirect your prescription if Solera cannot source the medication for you.

YOU HAVE THE RESPONSIBILITY TO:

1. Adhere to the plan of treatment or services established by your physician and notify your physician and pharmacist of any side effects.
2. Participate in the development of an effective plan of care/treatment/services.
3. Notify your treatment provider of participation in SOLERA Pharmacy's patient management program.
4. Provide, to the best of your knowledge, accurate and complete medical and personal information necessary to plan and provide care/services.
5. Ask questions about your care, treatment and/or services, or to have clarified any instructions provided by Solera representatives.
6. Communicate any information, concerns and/or questions related to perceived risks in your services, and unexpected changes in your condition
7. Choose the delivery type for your medications and notify Solera if you are going to be unavailable for scheduled delivery times.
8. Treat Solera personnel with respect and dignity without discrimination as to color, religion, sex, or national or ethnic origin.
9. 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.
10. Solera should be notified of any changes in your physical condition, physician's prescription or insurance coverage. Notify Solera immediately of any address or telephone changes whether temporary or permanent.
11. Pay all invoices upon receipt, and understand that unpaid accounts will be considered in default if not paid within sixty days, after which a default charge will be imposed at 1.5% per month on unpaid balances or the maximum legal interest rate, whichever is lower; and, if applicable, Pay the default charge together with reasonable attorney's fees and costs of collection.
12. Understand that Solera acts solely as an agent for you in filling for insurance or other benefits assigned to Solera; Understand that Solera assumes no responsibility for assuring that benefits so assigned will be paid; and understand that your account will only be credited when Solera actually receives payment.
13. Submit any forms that are necessary to participate in SOLERA Pharmacy's patient management program, to the extent that is required by law.
14. Keep track of your refill dates and give 7 days for any refill request
15. Be the only one using the medications provided.
16. Use the medications as ordered.
17. Follow the Terms of Service
18. Provide Solera staff with names and contact information for approved Caregivers and/or Emergency contacts.

Notice of Privacy Practices, Patient Rights and Responsibilities

Please sign below that you have received a copy of Solera's Notice of Privacy Practices, 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 Solera immediately)

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

Please fill out and return this form to Solera in the enclosed envelope.

Phone: 954-615-1840
Toll-free: 877-712-7864
www.SoleraRX.com

Fax:954-634-3939
Toll-free: 877-712-7866

I hereby authorize Solera Specialty Pharmacy,LLC and their employees, agents and contractors (collectively "**Solera 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 Solera 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 Solera 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 Solera-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 Solera Pharmacy location which serves me, provided that such revocation shall not be effective with respect to any use or disclosure made by Solera Pharmacy in reliance on this Authorization prior to the date of Solera Pharmacy's receipt of my revocation.

I understand that Solera Pharmacy cannot require me to sign this Authorization in order receive treatment unless the provision of health care by Solera 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 Solera Pharmacy will not provide the service unless I sign this Authorization.

I understand that the information used or disclosed by Solera 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 Solera 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 Authorization is Requested by Solera Pharmacy]

I understand that if this Authorization is being requested by Solera Pharmacy, Solera 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 Solera 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 Patients Authorized Representative _____

Patient Representative Name (Print) _____

Basis of authority to sign for patient: _____