



Dear Patient,

Welcome to 986 Specialty Pharmacy! We are excited about the opportunity to serve you for all your pharmacy needs.

Our mission is simple which is to keep our patient's body temperature at 98.6°F. We're built collectively but run independently. Our stores maximize speed and offer free delivery for your convenience to make it that much easier. We provide more services to manage your health's progress because we're all about more doctor from your pharmacist.

The staff at 986 Specialty Pharmacy understand that your medical condition is complex and requires special knowledge when collaborating with your medical provider and insurance company. We are dedicated to providing you with the personal service necessary to ensure that you achieve the most benefit from your therapy including:

- Access to clinically-trained pharmacists on-site Monday-Friday: 9:00am-6:00pm, Saturday: 9:00 am – 4:00 pm
- Access via phone to clinically trained pharmacists 24/7/365
- Assistance with verifying insurance benefits
- Obtaining additional financial assistance when available
- Monthly refill reminders
- Confidential packaging and convenient delivery

**Contact Information and Hours of Operations**

Phone: **(626) 850-5318 or (833) 986-6253 (toll free)**  
Fax: **(626) 850-5319**  
Website: **www.986pharmacy.com**  
E-mail: **Specialty1@986pharmacy.com**  
Hours: **Monday - Friday 9:00 AM - 6:00 PM**  
**Saturday 9:00 AM – 4:00 PM**

986 handles all private pay, Medicare, Medicaid, and self-funded plans to help pay for medication. Prescription are accepted 24 hours, 7 days a week by telephone, fax, or email.

986 Pharmacist is available 24 hours a day at (626) 850-5318 or (833) 986-6253

**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 or sharps container
- Ask any questions regarding copayment assistance, your benefits and additional funding sources for your medication
- Request refills. We will reach out to you 7 days prior to you needing a refill. If you need to reach us sooner than this, please contact us at least *3 days prior* to needing your medication.

**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 986 Pharmacy as an out-of-network pharmacy per your insurance carrier
- Your pharmacist will coordinate with your 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.

**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

**Included in this Packet:**

Included in this packet you will find the following documents:

- **Patient Rights and Responsibilities**
- **Notice of Privacy Practices**
- **HIPAA Release Form**
- **Assignment of Benefits Release Form (if applicable)**
- **Patient Acknowledgement: Notice of Privacy Practices, Patient Rights and Responsibilities**

**Please sign and send back the following in the included pre-stamped envelope:**

HIPAA Release Form (if applicable), Assignment of Benefits Release Form (If applicable) and patient acknowledgement

We look forward to providing you with the best service possible. We know you have many options, and we thank you for choosing 986 Specialty Pharmacy.

Sincerely,

*986 Specialty Pharmacy Team*

# FIVE THINGS YOU CAN DO TO PREVENT INFECTION

It is important to try and avoid contagious diseases like the flu and the common cold. Follow these five easy steps to prevent the spread of infection.



Clean your Hands

Clean your hands thoroughly for at least 15 seconds. Use soap and warm water (be careful of the water temperature and use a temperature that is comfortable for you). Clean your hands after visiting a place of business,



Cover your mouth and nose

Germ's can travel 3 feet or more when you sneeze or cough. Always cover your mouth to prevent the spread of infection. You can sneeze or cough into a tissue or at the bend of your elbow. Always make sure you clean your hands right away after sneezing or coughing.



Avoid close contact with others if you are sick

If you are sick, stay away from others (if possible) and do not touch or shake hands with people. If you are visiting the doctor for treatment, call ahead and ask if there is anything you can do to further prevent spreading an infection.



Get your vaccinations

Healthcare providers come in contact with lots of bacteria and viruses. Do not be afraid to ask them if they should wear gloves or other forms of PPE (personal protective equipment) before they treat you.

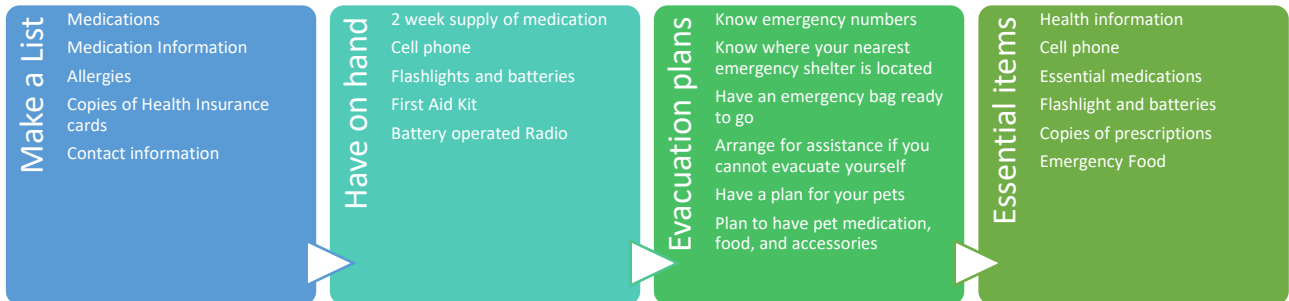


Ask your healthcare professionals to wash their hands and wear gloves

Make sure you are up-to-date on your vaccinations from your healthcare provider. Vaccinations are available for: chicken pox, measles, tetanus, Shingles, Mumps, Meningitis, Hepatitis, Pneumonia, and Flu (influenza)

## PATIENT EMERGENCY PLAN

It is important to have a general plan when preparing for an emergency. The following tips could be helpful during your preparation.



Should you have any questions during your preparation or in the event of an emergency, do not hesitate to call your 986 Pharmacist at 626-850-5318

## YOU HAVE THE RIGHT TO:

1. Obtain relevant, accurate, current and understandable information from your 986 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 986 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 986 Notice of Privacy Practices (NOPP).
6. Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality
7. Receive appropriate care without discrimination in accordance with physician orders.
8. Be advised if a medication has been recalled at the consumer level.
9. Call 986 with any grievances/complaints about medication or privacy matters at 626-850-5318 and ask for the Pharmacy Manager, or contact us about them through our website @ <http://986pharmacy.com> or contact the California Board of pharmacy at 916-574-7900. If 986 Specialty Pharmacy cannot help you solve your concerns, then you may call ACHC at 1-855-937-2242 (our accreditation agency that works with our Specialty customers) or contact URAC at [www.urac.org/complaint](http://www.urac.org/complaint) (our accreditation agency that works with our Specialty customers).
10. 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. Pharmacy will respond to complaint within 7 business days if not immediately addressed within 24 hours.
11. Be able to identify 986 Pharmacy representatives through proper identification, including name, job title, and request to speak with a supervisor if requested
12. Choose a healthcare provider.
13. Receive information about the scope of care/services that are provided by 986 Pharmacy directly or through contractual arrangements, as well as any limitations to 986' Pharmacy's care/service capabilities.
14. 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.
15. Be informed of any financial benefits that might accrue when you are referred to an organization.
16. Be advised of any change in 986 Pharmacy's plan of service before the change is made.
17. Receive information in a manner, format and/or language that you understand.
18. 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.
19. Be fully informed of your responsibilities.
20. Be informed about Generic or other substitutions to prescribed medications.
21. Be informed promptly of any manufacturer/FDA recalls affecting your prescribed medications.
22. If 986 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
23. Be informed of patient assistance programs to assist with access to medications.
24. Redirect your prescription if 986 Pharmacy cannot source the medication
25. Decline participation, revoke consent, or disenroll from 986 Pharmacy's patient management program at any point in time.
26. Be informed about the philosophy and the characteristics of 986 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 986 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 986 Pharmacy if you are going to be unavailable for scheduled delivery times.
7. Treat 986 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. 986 Pharmacy should be notified of any changes in your physical condition, physician's prescription or insurance coverage. Notify 986 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 986 Pharmacy acts solely as an agent for you in filling prescriptions through your insurance or other benefits assigned to 986 Pharmacy; Understand that 986 Pharmacy assumes no responsibility for ensuring that benefits so assigned will be paid; and understand that your account will only be credited when 986 Pharmacy actually receives payment.
12. Submit any forms that are necessary to participate in 986 Pharmacy's patient management program, to the extent that is required by law.
13. Notify your treatment provider of participation in 986 pharmacy.

I hereby authorize 986 Pharmacy and their employees, agents and contractors (collectively "986 Pharmacy"), to use or disclose, as specified in this Authorization, my "protected health information" (PHI) 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 986 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 Patient Satisfaction, Concerns and Complaints

## 986 PHARMACY NOTICE OF PRIVACY PRACTICES

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### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Facility has created this Notice of Privacy Practices (Notice). This Notice describes the Facility's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that the Facility protect the privacy of your PHI that the Facility has received or created.

This Facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The Facility reserves the right to change the Facility's privacy practices and this Notice.**

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#### HOW THE FACILITY MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways that the Facility is permitted, by law, to use and disclose your PHI.

**Uses and disclosures of PHI for Treatment:** We will use the PHI that we receive from you to fill your prescription and coordinate or manage your health care.

**Uses and disclosures of PHI for Payment:** The Facility will disclose your PHI to obtain payment or reimbursement from insurers for your health care services.

**Uses and disclosures of PHI for Health Care Operations:** The Facility may use the minimum necessary amount of your PHI to conduct quality assessments, improvement activities, and evaluate the Facility workforce.

The following is an accounting of additional ways in which the Facility is permitted or required to use or disclose PHI about you without your written authorization.

**Uses and disclosures as required by law:** The Facility is required to use or disclose PHI about you as required and as limited by law.

**Uses and disclosure for Public Health Activities:** The Facility may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purpose of preventing or controlling disease, injury, or disability. This includes the FDA so that it may monitor any adverse effects of drugs, foods, nutritional supplements and other products as required by law.

**Uses and disclosure about victims of abuse, neglect or domestic violence :** The Facility may use or disclose PHI about you to a government authority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.

**Uses and disclosures for health oversight activities:** The Facility may use or disclose PHI about you to a health oversight agency for oversight activities which may include audits, investigations, inspections as necessary for licensure, compliance with civil laws, or other activities the health oversight agency is authorized by law to conduct.

**Disclosures to Individuals Involved in your Care:** The Facility may disclose PHI about you to individuals involved in your care.

**Disclosures for judicial and administrative proceedings:** The Facility may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Facility.

**Disclosures for law enforcement purposes:** The Facility may disclose PHI about you to law enforcement officials for authorized purposes as required by law or in response to a court order or subpoena.

**Uses and disclosures about the deceased:** The Facility may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.

**Uses and disclosures for cadaveric organ, eye or tissue donation purposes:** The Facility may use and disclose PHI for the purpose of procurement, banking, or transplantation of cadaveric organs, eyes, or tissues for donation purposes.

**Uses and disclosures for research purposes:** The Facility may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, the Facility will request a signed authorization by the individual for all other research purposes.

**Uses and disclosures to avert serious threat to health or safety:** The Facility may use or disclose PHI about you, if it believed in good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.

**Uses and disclosures for specialized government functions:** The Facility may use or disclose PHI about you for specialized government functions including; military and veteran's activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.

**Disclosure for workers' compensation:** The Facility may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

**Disclosures for disaster relief purposes:** The Facility may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.

**Disclosures to business associates:** The Facility may disclose PHI about you to the Facility's business associates for services that they may provide to or for the Facility to assist the Facility to provide quality health care. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create

#### OTHER USES AND DISCLOSURES

The Facility may contact you for the following purposes:

**Information about treatment alternatives:** The Facility may contact you to notify you of alternative treatments and/ or products.

**Health related benefits or services:** The Facility may use your PHI to notify you of benefits and services the Facility provides.

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**Fundraising:** If the Facility participates in a fundraising activity, the Facility may use demographic PHI to send you a fundraising

packet, or the Facility may disclose demographic PHI about you to its business associate or an institutionally related foundation to send you a fundraising packet. No further disclosure will be allowed by the business associates or an institutionally related foundation without your written authorization. You will be provided with an opportunity to opt-out of all future fundraising activities.

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#### **FOR ALL OTHER USES AND DISCLOSURES**

The Facility will obtain a written authorization from you for all other uses and disclosures of PHI, and the Facility will only use or disclose pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact 986 Privacy Officer to obtain a Request for Restriction of Uses and Disclosures.

#### **YOUR HEALTH INFORMATION RIGHTS**

The following are a list of your rights in respect to your PHI. Please contact the Privacy Officer for more information about the below.

**Request restrictions on certain uses and disclosures of your PHI:** You have the right to request additional restrictions of the Facility's uses and disclosures of your PHI; however, the Facility is not required to accommodate a request. This includes the right to restrict disclosures to Insurances for those products and services you pay out-of-pocket for.

**The right to have your PHI communicated to you by alternate means or locations:** You have the right to request that the Facility communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Facility to have an accurate address and home phone number in case of emergencies. The Facility will consider all reasonable requests.

**The right to inspect and/or obtain a copy your PHI:** You have the right to request access and/or obtain a copy of your PHI that is contained in the Facility for the duration the Facility maintains PHI about you. There may be a reasonable cost-based charge for photocopying documents.

You will be notified in advance of incurring such charges, if any.

**The right to amend your PHI:** You have the right to request an amendment of the PHI the Facility maintains about you, if you feel that the PHI the Facility has maintained about you is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If we do deny the request, you will have the right to have the denial reviewed by someone we designate who was not involved in the initial review. You may also ask the Secretary, United States Department of Health and Human Services ("HHS"), or their appropriate designee, to review such a denial.

**The right to receive an accounting of disclosures of your PHI:** You have the right to receive an accounting of certain disclosures of your PHI made by the Facility.

**The right to receive additional copies of the Facility's Notice of Privacy Practices:** You have the right to receive additional paper copies of this Notice, upon request, even if you initially agreed to receive the Notice electronically

**Notification of Breaches:** You will be notified of any breaches that have compromised the privacy of your PHI.

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#### **REVISIONS TO THE NOTICE OF PRIVACY PRACTICES**

The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility.

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#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact the Privacy Officer if you wish to file a complaint with the Secretary, please write

to: <http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html>

The Facility will not take any adverse action against you as a result of your filing of a complaint

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#### **CONTACT INFORMATION**

If you have any questions on the Facility's privacy practices or for clarification on anything contained within the Notice, please contact: **(626) 850-5318 or (833)-986-6253**

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
- The following selected items (Please Specify): \_\_\_\_\_

**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 986 Pharmacy staff, including pharmacists, technicians, navigators, and clinical staff
- Only the following persons (Please Specify): \_\_\_\_\_

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

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

Name:	Relationship:

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

- Inability or unavailability to respond to 986-specific questions and services
- I am requesting the disclosure of my PHI pursuant to this Authorization, and the information will be used and disclosed at my request.
- Other (Please Specify): \_\_\_\_\_

**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 986 Pharmacy location which serves me, provided that such revocation shall not be effective with respect to any use or disclosure made by 986 Pharmacy in reliance on this Authorization prior to the date of 986 Pharmacy's receipt of my revocation.

I understand that 986 Pharmacy cannot require me to sign this Authorization in order receive treatment unless the provision of health care by 986 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 986 Pharmacy will not provide the service unless I sign this Authorization.

I understand that the information used or disclosed by 986 Pharmacy pursuant to this Authorization may be subject to redisclosure 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 986 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.

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**Applicable if Authorization is Requested by 986 Pharmacy**

I understand that if this Authorization is being requested by 986 Pharmacy, 986 Pharmacy must provide me with a copy of the Signed Authorization.

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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 986 Pharmacy (as defined above) from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

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

**Patient Representative (Print):** \_\_\_\_\_ **Representative Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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

Please sign below that you have received a copy of the 986 Pharmacy's 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 986 Pharmacy immediately)

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

**Please fill out and return this form to 986 Pharmacy in the enclosed envelope.**