KENTUCKY PHARMACY PROVIDER PROGRAM
PARTICIPATING PHARMACY AGREEMENT

I will participate in the Kentucky Pharmacy Provider Program, a program of the Kentucky Pharmacists Association and a component of Health Kentucky, Inc. By virtue of my agreement to be a participating pharmacy provider, I will waive all fees for prescriptions filled for Kentucky Physicians Care patients, when those prescriptions are written for products from pharmaceutical manufacturers who have an agreement with Health Kentucky, Inc., to replace to my inventory their products which were dispensed through my pharmacy. I agree to participate in periodic audits conducted by a participating pharmaceutical manufacturer or their representative should my pharmacy be selected for the review.

I understand that my participation in this "safety net" program is totally voluntary and I may terminate this agreement at any time by sending written notification to the Kentucky Pharmacists Association.

PHARMACY NAME: _____

PHARMACY NABP# _____ DEA # _____

STREET ADDRESS _____

CITY _____ COUNTY_____ ZIP CODE_____

PHONE # _____ FAX # _____ EMAIL ADDRESS _____

COUNTY _____ E-MAIL ADDRESS _____

STATE PHARMACY LICENSE NO: _____ EXP. DATE: _____

PHARMACIST/CONTACT PERSON _____

SIGNATURE _____ DATE _____

Please complete and <u>mail</u> to:

Health Kentucky, Inc.
140 Consumer Lane
Frankfort, Kentucky 40601
(502) 227-3158