OREGON CRITICAL ACCESS PHARMACY EXCEPTION FORM

(SPECIFIC TO THE ARRAYRX PROGRAM ONLY)

Oregon Health Authority

Responses on this form will be used by the Oregon Prescription Drug Program & Pharmacy Purchasing Director to determine a potential exception to 431-121-2000(4), granting a pharmacy Critical Access Pharmacy status, as related to ArrayRx. Should an exception be granted, this would allow a pharmacy to be considered a Critical Access Pharmacy, specifically for the ArrayRx Program only.

APPLICANT INFORMATION:

Pharmacy name:____

Pharmacy Address: _______________________ **City:** ___________________ **Zip Code:**________

License Number: ____

NPI: ____

Contact Information: ____

GEOGRAPHY

☐ There is not another pharmacy near this pharmacy. Please specify distance of this pharmacy to the nearest other pharmacy: ____

*Please ensure that you provide the current address of the physical location of your pharmacy. There will also be an investigation, based on the pharmacy address provided within the Applicant Information box, to determine whether the subject pharmacy is within or adjacent to a high poverty census tract, within Oregon. This determination will factor into the decision.

SERVICES PROVIDED

☐ This pharmacy is compliant with the clinical services offerings required within 431-121-2000(4), which include: provide access to immunizations and either medication therapy management or pharmacist protocol-based prescribing.

☐ This pharmacy offers language interpretation services in addition to translation services.

☐ This pharmacy offers additional services that might qualify (examples: programs to monitor and address gaps in care related to adherence, blood pressure monitoring, and hemoglobin AIC testing. Please list any services this pharmacy provides: ____

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☐ This pharmacy serves Medicaid members. Specify percentage of the pharmacy's population served that are Medicaid members or volume of drugs dispensed as Medicaid______________________________

☐ This pharmacy provides extended business hours.

☐ This pharmacy provides after hours access.

☐ This pharmacy provides delivery to patients, upon request, at no charge to the patient.

ADDITIONAL JUSTIFICATION

Please provide your justification for exception (include additional pages, as needed):

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