Pharmacy Addendum

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CAN BE WRITTEN ON A CLAIMS MADE AND REPORTED BASIS OR ON A CLAIMS MADE/OCCURRENCE COMBINED BASIS, WHICH MEANS THAT SOME COVERAGES UNDER THE POLICY APPLY ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE INSURANCE COMPANY DURING THE POLICY PERIOD OR THE EXTENDED REPORTING PERIOD, IF APPLICABLE, OR OCCURRENCE TAKING PLACE DURING THE POLICY PERIOD. AMOUNTS INCURRED AS DEFENSE COSTS SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE RETENTION. PLEASE READ THIS APPLICATION CAREFULLY.

BACKGROUND INFORMATION – PLEASE READ:

1) Please type or print clearly.
2) Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3) If additional space is needed to answer any questions fully, please attach a separate page.
4) This Application must be completed, dated, and signed by either a Principal, C-suite Executive, Risk Manager or General Counsel of the Applicant.

1. Applicant (first named insured):

Professional Services

2. Annual Number of **Prescriptions**:

	Projected Next 12 Months	Past 12 Months	First Year Prior
Retail			
Wholesale			
Specialty			
General Compounding			
Sterile Compounding			
Opioids			
Other (describe) _____			
Total			

3. Annual Gross **Revenue**:

	Projected Next 12 Months	Past 12 Months	First Year Prior
Prescriptions			
Sundries			
Medical Equipment Sales			
Medical Equipment Rental			

Other (describe) _____			
Total			

4. If applicable, please provide the number of **patient contacts**: Not Applicable

	Projected Next 12 Months	Past 12 Months	First Year Prior
Clinic Visits			
Vaccines/Immunizations			
Infusion Therapy (IV)			
Other (describe) _____			

5. Provide the following information for all the states in which you are licensed (attach pages if necessary):

State	License Number	Effective	Expiration

6. Are you in compliance with all local, state, and federal laws that govern the manufacture, control, and fulfillment of prescriptions? Yes ☐ No ☐

7. Have you ever been subject to a Board of Pharmacy investigation or disciplinary action? Yes ☐ No ☐
   Please describe: _____

8. Please attach a copy of most recent on-site inspection.
   a. Date of inspection or survey: _____
   b. Was there a Corrective Action plan required? Yes ☐ No ☐
   c. Were all deficiencies noted on the action plan corrected? Yes ☐ No ☐

9. Are any dispensed prescriptions/drugs:
   a. Directly imported from outside the United States of America by the applicant? Yes ☐ No ☐
   b. Not Approved by the Food and Drug Administration? Yes ☐ No ☐
      Please describe: _____

10. Do you provide Pharmacy Benefit Management or Managed Care services? Yes ☐ No ☐
    Please describe: _____

11. Do you provide any specialized pharmacy services? Yes ☐ No ☐
    (example: nuclear, rare disease, orphan drugs, research/drug trials, importer, other)
    Please describe: _____

12. Are veterinary medications dispensed or compounded for cattle, food chain, or high value animals? Yes ☐ No ☐

13. Does applicant offer any mail order or delivery prescription services? Yes ☐ No ☐
    a. Mail Order ____%
    b. Delivery ____% Maximum miles traveled: _____
    c. Proper storage conditions maintained throughout delivery? Yes ☐ No ☐

d. Are there quality checks to ensure delivery of medications to the right place? Yes ☐ No ☐

e. Are delivery drivers required to provide medication instructions? Yes ☐ No ☐

f. For any contraceptives or abortion medication? Yes ☐ No ☐

Please describe: _____

g. Mailed or shipped to out of state residents? Yes ☐ No ☐

14. Do you accept verbal medication orders? Yes ☐ No ☐

a. Under what circumstances? _____

Compounding

Not Applicable

15. Are you a 503B Compounding Pharmacy or Registered Outsourcing Facility? Yes ☐ No ☐

16. Do you compound in bulk, manufacture, or wholesale medicine? Yes ☐ No ☐

Please describe: _____

17. Are individual prescriptions obtained for every compound dispensed? Yes ☐ No ☐

18. Do you compound any drugs in advance of receiving prescriptions? Yes ☐ No ☐

Please describe: _____

19. Do you compound any drugs that are copies of commercially available drug products? Yes ☐ No ☐

Please describe: _____

20. Do you compound drug products that have been removed from the market due to safety or efficacy issues?

Please describe: _____ Yes ☐ No ☐

Sterile Compounding

Not Applicable

21. Type(s) Performed:

a. Intrathecal and/or epidural spinal injectables Yes ☐ No ☐

b. Other sterile injectables (including HRT pellets) Yes ☐ No ☐

c. Sterile IV dosage forms Yes ☐ No ☐

d. Others: _____

22. Are all environmental testing results regarding sterile compounding documented? Yes ☐ No ☐

23. Are you compounding under a Laminar air flow hood? Yes ☐ No ☐

24. Are you compounding in a clean room? Yes ☐ No ☐

25. Are you QCCP Certified? Yes ☐ No ☐

26. Does your Quality Assurance program follow the parameters outlined within USP 797? Yes ☐ No ☐

Controlled Substance/Opioids

Not Applicable

27. What generic medication prescription types will you fill? _____

(For ex: oxycodone, hydrocodone, morphine, methadone, fentanyl, etc.)

28. Are you compliant with all Prescription Drug Monitoring Program (PDMP)/Prescription Monitoring Program (PMP) state-specific reporting requirements? Yes ☐ No ☐

29. Do you dispense formal, written policies to all staff regarding:

Continuing education on the Opioid Crisis	☐	☐
Dispensing of opioid amounts, including to single individuals at any one time	☐	☐
Ordering/receiving of scheduled drugs (who can order/receive)	☐	☐
Medication management	☐	☐
Early refill requests	☐	☐
Identifying and reporting missing Schedule II & III Substances	☐	☐

30. Does the applicant's provide services or operations involving THC/CBD, Ketamine, or Psilocybin? Yes ☐ No ☐

Please describe:

Risk Management

	Yes	No
Are there medication administration, dispensing, and storage policies/procedures in place?	☐	☐
Are pharmacists and technicians trained in applicant's procedures for responding to a serious medication error which includes disclosure to the patient and notification to the prescriber?	☐	☐
Are you a member of the Institute for safe Medication Practices (ISMP)?	☐	☐
Are drugs with look-alike drug names stored separately and not alphabetically?	☐	☐
Are competency skills checked for applicable aspects of medication management?	☐	☐
Is there a non-punitive medication error reporting process?	☐	☐
Is a unit-dose system used in the organization?	☐	☐
Are all prescriptions authorized by a licensed physician in the state where services are rendered?	☐	☐
Are all prescriptions, including high risk drugs, dispensed with current written instructions?	☐	☐
Do employees have access to drug information? (i.e. Drug Facts and Comparisons, Micromedex)	☐	☐

31. Does your Electronic Health Record System Include:

	Yes	No
A database with patient medication profiles, including allergies	☐	☐
Identification and alerts to the pharmacist of look-alike drug names, packaging, or labelling	☐	☐
Alerts for patient counseling	☐	☐
Detect drug contradictions, interactions and duplications against medical history or prescribed drugs	☐	☐
Pediatric dose checks and drug contraindications including error reductions	☐	☐

General Liability & Products Liability

Coverage not requested

32. Percentage of Building/Unit Occupied by Applicant: _____

    a. Other Occupancy (*example: supermarket)*: _____

33. If applicable, please offer breakdown for types of medical equipment sold (must total 100%):

Equipment	%	Equipment	%
Expendable Items		Diagnostic or Treatment Devices	
Non-Expendable Items		Life Sustaining/Critical Life Monitoring Devices	
Mobility Aids		Other (describe) _____	

34. Any rental of the above equipment to others?

    Please describe: _____

35. With regards to products sold, rented, or leased:

	Yes	No
Are written instructions for the use of the products provided to the user?	☐	☐
Do you modify any products in any way after their original manufacture?	☐	☐
Are any products sold under the applicant's label?	☐	☐
Are all devices and/or equipment checked, and their condition documented prior to their release?	☐	☐
Is preventative maintenance performed on all equipment & devices according to a written schedule?	☐	☐
Do you repair or sell used equipment for others?	☐	☐
Do you distribute oxygen cylinders?	☐	☐
Are manufacturer recommendations followed for all maintenance and repair of equipment?	☐	☐

36. Do you subcontract labor for installation, service, or repair of any products? Yes ☐ No ☐

    a. If yes, are certificates of insurance obtained? Yes ☐ No ☐

    b. At what limits? _____

37. Do operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? Yes ☐ No ☐

38. Any exposure to flammables, explosive, chemicals? Yes ☐ No ☐

39. How are drug wastes and expired drugs disposed?_____

SIGNATURE SECTION

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT TO SIGN THIS APPLICATION ON THE APPLICANT'S BEHALF AND DECLARES THAT THE STATEMENTS CONTAINED IN THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION AND THE UNDEWRITING OF THIS INSURANCE ARE TRUE, ACCURATE AND NOT MISLEADING. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION AND ANY OTHER INFORMATION AND MATERIALS SUBMITTED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING OF THIS INSURANCE ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY. FOR NORTH CAROLINA APPLICANTS, SUCH APPLICATION MATERIALS ARE PART OF THE POLICY, IF ISSUED, ONLY IF ATTACHED AT ISSUANCE.

THIS APPLICATION AND ALL INFORMATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY AS IT DEEMS NECESSARY REGARDING THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING AND ISSUANCE OF THE POLICY.

THE APPLICANT AGREES THAT IF THE INFORMATION PROVIDED IN THIS APPLICATION OR IN CONNECTION WITH THE UNDERWRITING OF THE POLICY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

I HAVE READ THE FOREGOING APPLICATION FOR INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO, AND RHODE ISLAND APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD THE INSURER BY SUBMITTING AN APPLICATION CONTAINING A FALSE STATEMENT AS TO ANY METERIAL FACT MAY BE VIOLATING STATE LAW.

NOTICE TO KENTUCKY, NEW JERSEY, OHIO, AND PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIMS CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT

OF CLAIMS CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY. IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signed*:_____ Date:_____

Print Name: _____ Title: _____
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa, please provide the Insurance Agent's name and signature only.

Agent's Printed Name:

Florida Agent's License Number:

Agent's Signature:

*If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a keypad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

Electronic Signature and Acceptance – Authorized Representative

Electronic Signature and Acceptance - Producer