



Department of Health and Wellness
Pharmacy Provider Confirmation of Agreement

Name of Provider \_\_\_\_\_ Provider No. \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_ Effective Date \_\_\_\_\_

Check applicable boxes below:

- By checking this box, it is certified the above provider accepts the terms and conditions of the Pharmacy Service Agreement...
By checking this box, it is certified the above provider accepts the terms and conditions of the Pharmacare Tariff Agreement...

This provider confirms that all claims under the Pharmacare Tariff Agreement will be submitted on the basis of drug cost of either the actual acquisition cost (AAC) or the maximum allowable reimbursement level specified in the Nova Scotia Formulary.

My Usual and Customary Dispensing Fees (\$) charged to cash customers and my Usual and Customary Service Fees charged to customers ineligible for public funding for services are:

Dispensing fee for ostomy supplies: \_\_\_\_\_ Service fee for assessment and prescribing for uncomplicated cystitis: \_\_\_\_\_

Dispensing fee for compounded extemporaneous products (except injectables): \_\_\_\_\_ Service fee for assessment and prescribing for herpes zoster: \_\_\_\_\_

Dispensing fee for methadone: \_\_\_\_\_ Service fee for contraception management assessment and prescribing: \_\_\_\_\_

Dispensing fee for all other prescriptions: \_\_\_\_\_ Service fee for prescription renewals: \_\_\_\_\_

On behalf the provider, I certify the foregoing represents an accurate statement of the Usual and Customary Dispensing Fees in effect for the above provider. I understand that Usual and Customary Dispensing Fees mean the dispensing fees charged to customers who pay cash for their prescriptions.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Authorized Signatory of Provider (Printed Name) \_\_\_\_\_ Title \_\_\_\_\_

Authorized Signature