Dear Patient,

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

The staff at Alps 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, 8:00am-5:00pm
- 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:	**417-719-4510** or **844-645-2577 (toll free)**
Website:	**specialty.alpspharmacy.com**
E-mail:	**specialty@alpspharmacy.com**
Hours:	**Monday - Friday 8:00 AM - 5:00 PM**

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 Alps Pharmacy as an out-of-network pharmacy per your insurance carrier
- You 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.
- Please let your Alps Pharmacy staff know at least 72 hours prior to needing a refill of your medication.
- Alps staff and pharmacist will answer any and all questions related to the disposal of medications.
- Alps staff will also educate you on the proper disposal of syringes and materials contaminated with bodily fluids.

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

Strengths and Limitations:

Strengths:

- Higher adherence rates (over 90% overall – we are 30% higher than national retail average)
- Save you money directly (copay cards and PAP's) and indirectly (adherence rates and avoidance of hospitalizations)
- More personal and regular communication with your care team, including ALPS pharmacists

Limitations:

- Frequent calls and follow-ups – patients and MD's have to spend more time with us
- We can't source EVERY drug- some are limited by manufacturers and payors
- We cannot find financial assistance for EVERYONE, but we will exhaust all opportunities to find you funding
-

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 Alps Specialty Pharmacy.

Sincerely,

Alps Specialty Pharmacy Team

2828 N National Ave. Ste B ● Springfield, MO 65803
Phone 417-719-4510 ● Fax 417-893-3908
specialty.alpspharmacy.com

Last Revised: 1/29/2018
Version 2.2

Patient Right and Responsibilities

YOU HAVE THE RIGHT TO:

1. Obtain relevant, accurate, current and understandable information from your ALPS 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 ALPS 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 ALPS Notice of Privacy Practices (NOPP).
6. Receive appropriate care without discrimination in accordance with physician orders.
7. Be advised if a medication has been recalled at the consumer level.
8. Call ALPS with any complaints at 417-719-4510 and ask for the Pharmacy Manager, or contact us about them through our website @ http://specialty.alpspharmacy.com or contact the Missouri Board of pharmacy at 573-751-0091.
9. 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.
10. Be able to identify ALPS Pharmacy representatives through proper identification, including name, job title, and request to speak with a supervisor if requested
11. Choose a healthcare provider.
12. Receive information about the scope of care/services that are provided by ALPS Pharmacy directly or through contractual arrangements, as well as any limitations to ALPS' Pharmacy's care/service capabilities.
13. 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.
14. Be informed of any financial benefits that might accrue when you are referred to an organization.
15. Be advised of any change in ALPS Pharmacy's plan of service before the change is made.
16. Receive information in a manner, format and/or language that you understand.
17. 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.
18. Be fully informed of your responsibilities.
19. Be informed about Generic or other substitutions to prescribed medications.
20. Be informed promptly of any manufacturer/FDA recalls affecting your prescribed medications.
21. If ALPS 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
22. Be informed of patient assistance programs to assist with access to medications.
23. Redirect your prescription if ALPS Pharmacy cannot source the medication
24. Decline participation, revoke consent, or disenroll from ALPS Pharmacy's patient management program at any point in time.
25. Be informed about the philosophy and the characteristics of ALPS 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 ALPS 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 ALPS Pharmacy if you are going to be unavailable for scheduled delivery times.
7. Treat ALPS 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. ALPS Pharmacy should be notified of any changes in your physical condition, physician's prescription or insurance coverage. Notify ALPS 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 ALPS Pharmacy acts solely as an agent for you in filling prescriptions through your insurance or other benefits assigned to ALPS Pharmacy; Understand that ALPS Pharmacy assumes no responsibility for ensuring that benefits so assigned will be paid; and understand that your account will only be credited when ALPS Pharmacy actually receives payment.
12. Submit any forms that are necessary to participate in ALPS Pharmacy's patient management program, to the extent that is required by law.
13. Notify your treatment provider of participation in ALPS Pharmacy's patient management program.

I hereby authorize ALPS Pharmacy and their employees, agents and contractors (collectively "**ALPS 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

ALPS PHARMACY
NOTICE OF PRIVACY PRACTICES

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.

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.**

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 a 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.

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.

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 Alps 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.

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.

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-hqadd resses.html
The Facility will not take any adverse action against you as a result of your filing of a complaint

CONTACT INFORMATION

If you have any questions on the Facility's privacy practices or for clarification on anything contained within the Notice, please contact:

Food Merchants LLC Privacy Officer
PO Box 397
Nixa, Mo. 65714
(417) 374 - 7505

HIPAA Release Form

1996 ("**HIPAA Privacy Rule**"). I understand that "protected health information" includes records disclosed to ALPS 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 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 ALPS 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 ALPS-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 ALPS Pharmacy location which serves me, provided that such revocation shall not be effective with respect to any use or disclosure made by ALPS Pharmacy in reliance on this Authorization prior to the date of ALPS Pharmacy's receipt of my revocation.

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

I understand that the information used or disclosed by ALPS 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 ALPS 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.

Applicable if Authorization is Requested by ALPS Pharmacy

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

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 ALPS 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 Name (Print): _____ **Patient Signature:** _____ **Date:**_____

2828 N National Ave. Ste B ● Springfield, MO 65803
Phone 417-719-4510 ● Fax 417-893-3908
specialty.alpspharmacy.com

Last Revised: 1/29/2018
Version 2.2

Patient Representative (Print): _____ Representative Signature: _____

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

Please sign below that you have received a copy of the Alps 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 Alps Pharmacy immediately)

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

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

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Patient Safety

Adverse drug reactions:

Patients experiencing adverse drug reactions, acute medical symptoms or other problems should contact their primary care provider (PCP), local emergency room or 911.

Hand-washing instructions Infections are serious issues. The best way to make sure you do not get an infection is to wash your hands often. Remember to always wash your hands before and after you prepare or handle any medication.

1. Collect the supplies:
   a. Soap
   b. Paper towels or a clean cloth towel
2. Wet your hands with warm water
3. Place a small amount of soap on your hands
4. Rub your hands briskly together for at least 30 seconds
5. Don't forget about the in-betweens of your fingers
6. Rinse your hands with warm water
7. Dry your hands with a paper towel or clean cloth towel
8. Turn off your faucet with the towel
9. If you touch anything (your hair, for example), sneeze into your hands or feel that your hands may no longer be clean, wash your hands again before continuing with your care. If no water supply is available, use an alcohol-based antibacterial hand cleanser

How to throw away home-generated biomedical waste:

Home-generated biomedical waste is any type of syringe, lancet or needle ("sharps") used in the home to either inject medication or draw blood. Special care must be taken with the disposal of these items to protect you and others from injury, and to keep the environment clean and safe.

If your therapy involves the use of needles, an appropriately sized sharps container will be provided. Please follow these simple rules to ensure your safety during your therapy.

Sharps:

After using your injectable medication, place all needles, syringes, lancets and other sharp objects into a sharps container. If a sharps container is not available, a hard plastic or metal container with a screw-on top or other tightly securable lid (for example, an empty hard can or liquid detergent container) could be used. Before discarding, reinforce the top with heavy-duty tape. Do not use clear plastic or glass containers. Containers should be no more than ¾ full.

Disposal:

Check with your local waste collection service to verify the disposal procedures for sharps containers in your area. You can ask your prescriber's office about the possibility of disposing of items in the prescriber's office during your next office visit. You can also visit the Centers for Disease Control and Prevention (CDC) Safe Community Needle Disposal website at http://www.cdc.gov/needledisposal/.

Needle-stick safety:

- Never replace the cap on needles.
- Throw away used needles immediately after use in a sharps disposal container.
- Plan for the safe handling and disposal of needles before using them.
- Report all needle stick or sharps-related injuries promptly to your physician

If your therapy does not involve the use of needles or sharp items you do not need a sharps container. You should place all used supplies (e.g., syringes or tubing) in a bag you can't see through. Put this bag inside a second bag, and put this in your garbage with your other trash.

2018 Patient Satisfaction Survey

2828 N. National Ave. Suite B
Springfield, Mo. 65803

Gender:
- ❑ Male
- ❑ Female

Age:
- ❑ Senior (65+)
- ❑ Adult (20-64)
- ❑ Teen (13-19)
- ❑ Child (3-12)
- ❑ Infant (0-2)

I was referred to Alps Specialty by:
- ❑ Alps Service Representative
- ❑ Doctors Office
- ❑ Case Manager/Social Worker
- ❑ Insurance Company
- ❑ Friend/Family
- ❑ Manufacturer/HUB Program
- ❑ Other_____

Prior to using Alps I utilized (check all that apply):
- ❑ Walgreens
- ❑ CVS
- ❑ Other Chain Pharmacy(Walmart, Target, Price Cutter, etc)
- ❑ Other Independent Pharmacy(Diplomat, ShoMe, Grove, Family, etc)
- ❑ Mail-order Pharmacy (Accredo, Caremark, Alliance)
- ❑ Other_____

Person completing this survey:
- ☐ Patient
- ☐ Caregiver
- ☐ Parent
- ☐ Other _____

What state do you reside in?:
- ❑ _____

	Strongly Agree	Agree	Disagree	Strongly Disagree
My medications are delivered / shipped / ready for pickup on time?	▢	▢	▢	▢
My order is complete	▢	▢	▢	▢
Questions about my medications are answered quickly and completely	▢	▢	▢	▢
Pharmacy staff is friendly	▢	▢	▢	▢
Pharmacy staff is knowledgeable	▢	▢	▢	▢
Pharmacy staff is capable of solving problems	▢	▢	▢	▢
Pharmacy staff is PROACTIVE in solving problems	▢	▢	▢	▢
Alps Specialty Pharmacy does a better job than my previous pharmacy	▢	▢	▢	▢
I would recommend Alps Specialty Pharmacy to a friend	▢	▢	▢	▢

Did you know that we offer (Check ALL that apply)
- ❑ Free Delivery/Shipping
- ❑ Help with Prior Authorizations
- ❑ Help in choosing a Medicare Part D Plan
- ❑ Help in locating Copayment/Foundation Assistance
- ❑ Special Compliance Packaging (DisPill)

I receive my medications by: (check ALL that apply)
- ❑ Pickup at the Pharmacy
- ❑ Delivery to my home or business
- ❑ Shipment to my home or business

Overall, Are you satisfied with the services you receive from Alps Specialty Pharmacy?

- ❑ **Yes**
- ❑ **No**

If you have any suggestions on how we can improve our services, or additional comments to make, please enter them to the right.