Community Pharmacy Agreement

QUALITY USE OF MEDICINES MAXIMISED FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE (QUMAX)

QUMAX DOSE ADMINISTRATION AID AGREEMENT 2018–2019

FORM A

OFFICE USE ONLY
Reference No.:
Received:
Approved for payment:

For applications to be valid, Parts 1–3 of this form and Banking and RCTI Agreement (Form B) must be completed and declarations must be signed. Further information about the QUMAX Programme is available online at www.6cpa.com.au

PART 1 – COMMUNITY PHARMACY DETAILS (Community Pharmacy to complete this section)

Community Pharmacy must also complete FORM B (Banking Details and RCTI Agreement) to ensure payments are made.

Indicate whether this is a ☐ **New Application** or ☐ **Renewal Application**

Community Pharmacy Details

Pharmacy Name:

Pharmacy Owner's Name:

Name of Authorised Pharmacy Contact *(QUMAX Contact Person)*:

Pharmacy ABN:

Pharmacy Approval Number:

Pharmacy Physical Address:

Pharmacy Postal Address:
☐ *Same as physical address*

Pharmacy Email Address:

Pharmacy Phone Number:

PART 2 – AGREEMENT (Community Pharmacy to complete this section with ACCHS)

Please use this section to outline the agreed upfront arrangement for the provision of Dose Administration Aids (DAAs) to eligible QUMAX clients for 1 July to 30 June.

QUM CATEGORY	AGREEMENT DETAILS	(3) FUNDING NEGOTIATED (1 July to 30 June)
Dose Administration Aid (DAA) Arrangement*	**(1)** Total number of QUMAX patients receiving DAA service per week = *(must be completed)*	**(1)** DAAs per week x **(2)** DAA unit price x 52 weeks = **(3)** Funding negotiated
	Total number of DAA packs provided per week =	
	(2) DAA unit price* *(GST exclusive)* = $	

* *DAA unit price includes time taken to collate accurate medication profile and provide prescription requests to the ACCHO when required.*

Please use this section to outline the agreed feedback to the ACCHO for the provision of DAAs (such as compliance issues – DAAs not collected, returned unused and total volume dispensed etc.).

AGREED FEEDBACK TO THE ACCHO *(We strongly suggest pharmacies contact their ACCHO to make arrangements in regard to the provision of reporting and feedback directly to their ACCHO)*

COMMUNITY PHARMACY DECLARATION

I confirm that:

- The Community Pharmacy (named above) is providing the QUMAX DAA Service as specified above to the rural or urban Aboriginal Community Controlled Health Organisation (ACCHO) named below in accordance to the QUMAX Programme Specific Guidelines ;
- The ACCHO named below have provided appropriate advice on local Aboriginal and Torres Strait Islander community arrangements and health issues;
- I will provide evidence of the supply of Dose Administration Aids on a four monthly basis to The Pharmacy Guild of Australia;
- I have completed Form B (Banking Details and RCTI agreement) to allow The Pharmacy Guild of Australia to make payments for provision of the negotiated QUMAX DAA Agreement;
- I agree to supply feedback as specified above in Agreed Feedback to the ACCHO;
- I will notify the ACCHO and The Pharmacy Guild of Australia in writing two months prior to ceasing the QUMAX DAA Agreement; and
- The information contained in this Agreement is confidential, cannot be divulged to a third party and can only be used for its intended purposes.

I declare that the information given by me in this application is true and correct.

Signature of Owner	*Date*

PART 3 – ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

(Chief Executive Officer or Medical Director to complete this section)

Name of ACCHO	
Outstations/Auspices *(if relevant to this agreement)*	
Name of QUMAX contact person	
ACCHO Street Address	
ACCHO Postal Address	
ACCHO Email Address	
ACCHO Phone Number	

ACCHO DECLARATION

I declare that:

- The ACCHO (named above) has entered into an agreement with the Community Pharmacy (named above) for the provision of QUMAX support services in accordance with the QUMAX Programme Specific Guidelines made under the Sixth Community Pharmacy Agreement;
- Payment for other QUM categories will be made in accordance to locally arranged payment schedule;
- This ACCHO will notify the Community Pharmacy and The Pharmacy Guild of Australia in writing two months prior to ceasing the QUMAX Service Agreement; and
- The information contained in this agreement is confidential, cannot be divulged to a third party and can only be used for its intended purposes.

Signature of ACCHO CEO	*Date*

CONTACT

QUMAX Support Team
The Pharmacy Guild of Australia
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For more information, please telephone:

QUMAX Hotline: 1300 764 088
NACCHO Phone: 02 6246 9300