Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People – Dose Administration Aids (DAA) Agreement

# Part 1 – Community Pharmacy Details

Community Pharmacy to complete this section

|  |  |  |  |
| --- | --- | --- | --- |
| Please indicate whether this is a: | New Application | or | Renewal Application |

### Community Pharmacy Details

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pharmacy Name: |  | | | | | |
| Pharmacy Owner: | Given Name(s) | | Family Name | | | |
| Authorised Person: | Given Name(s) | | Family Name | | | |
| Pharmacy ABN: |  | | | | | |
| Pharmacy Approval Number: |  | | | | | |
| Pharmacy Address: | Physical address | | | | | |
| Suburb | State | | | Postcode | |
| Postal Address: | Is the postal address the same as above? | | | Yes | | No |
| Physical address | | | | | |
| Suburb | State | | | Postcode | |
| Pharmacy Phone Number: |  | | | | | |
| Mobile Number: |  | | | | | |
| Email Address: |  | | | | | |

# Part 2 – Agreement

Community Pharmacy to complete this section with ACCHO

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.

|  |  |  |
| --- | --- | --- |
| Total number of QUMAX Patients receiving DAA service per week:  Must be completed | QUMAX DAA Patients |  |
| Total number of DAA packs provided per week: | DAAs per week | X |
| DAA unit price\* (GST exclusive) = $      x 52 weeks: | DAA unit price x 52 weeks  $ |  |
| Funding negotiated = | $ |  |

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

### Agreed Feedback to the ACCHO

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).

|  |
| --- |
| 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 |  | (insert name) |

is providing the QUMAX DAA Service as specified above to the rural or urban ACCHO named below in accordance with 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 Programs Administrator;
* I agree to supply feedback as specified above in Agreed Feedback to the ACCHO;
* I will notify the ACCHO and The Pharmacy Programs Administrator 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 Pharmacy Owner: |  | Date: |  |
| Full name: |  | | |

# 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: | Given Name(s) | | Family Name | | | |
| ACCHO Address: | Physical address | | | | | |
| Suburb | State | | | Postcode | |
| Postal Address: | Is the postal address the same as above? | | | Yes | | No |
| Physical address | | | | | |
| Suburb | State | | | Postcode | |
| Phone Number: |  | | | | | |
| Mobile Number: |  | | | | | |
| Email Address: |  | | | | | |

## 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 Rules 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 Programs Administrator 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:** |  |
| Full name: |  | | |

|  |  |
| --- | --- |
|  | CONTACT THE SUPPORT CENTRE: 1800 951 285 | support@ppaonline.com.au |