INSURANCE ASSISTANCE PROGRAM (IAP) PHARMACY SELECTION FORM

Return to:
Insurance Assistance Program (IAP)
2100 Bull Street
Columbia, SC 29201

FOR DAP USE ONLY - DO NOT WRITE IN THIS SPACE
Date Received:_____ Completed by: _____

This form is for selecting an IAP-approved pharmacy only. It cannot be used for DDP or MAP.

I. APPLICANT/ENROLLEE INFORMATION **DAP ID:**

Last Name:_____ First Name:_____ Full Middle Name: _____

Month/Year of Birth:_____/XX/_____ Last 4 of SSN: XXX-XX-_____

II. PHARMACY SELECTION

In order to begin receiving eligible medications through the SC Drug Assistance Program (DAP) under the Insurance Assistance Program (IAP) tier, please fill out this form and attach it to your application, when applicable.

Based on the information you provide, arrangements will be made for you to receive eligible medications from an approved pharmacy using your insurance, which must provide partial coverage. *Please note that if your insurance is not accepted for any reason, this will cause a delay or possibly prevent you from receiving your medications.* **Failure to complete this form in its entirety will delay the pharmacy enrollment process.**

Please check one of the following:

A. ☐ **Mandated Pharmacy:**

My insurance requires that I use a specific pharmacy (example: Medco Mail Order, Caremark Mail Order, etc.). Please indicate the name of the pharmacy your insurance requires you to use:

_____

B. ☐ **Pharmacy of Choice:**

I am able to use the pharmacy of my choice and would like to be enrolled with the DAP-IAP contracted pharmacy indicated below. *(You must select a pharmacy from the list below to complete the pharmacy enrollment process.)* For the most up-to-date list of pharmacies, please refer to the SC DAP website at:

www.scdhec.gov/adap **<<< Attach a copy of the front and back of your insurance card >>>**

- ☐ AIDS Healthcare Foundation – 4100 North Main Street, Ste. 102, Columbia, SC 29203
- ☐ Hawthorne Pharmacy - 1518 Taylor Street, Columbia, SC
- ☐ Hawthorne Laurel Pharmacy – 2761 Laurel Street, Columbia, SC 29204
- ☐ Long's (Avita) Drugs of Florence, South Carolina, Inc. – 360 N. Irby St, Florence, SC 29501
- ☐ Long's (Avita) Drugs of Lexington, South Carolina, Inc. – 1216 West Main Street, Lexington, SC 29072
- ☐ Long's (Avita) Drugstores of South Carolina, Inc. (Charleston) – 1481 Tobias Gadson Blvd Suite 2D, Charleston, SC 29407
- ☐ Long's (Avita) Drugstores of South Carolina, Inc. (Greenville) – 811 Pendleton St, Suite 10, Greenville South Carolina 29601
- ☐ Long's (Avita) Drugstores of South Carolina, Inc. (Rock Hill) – 455 Lakeshore Pkwy, Rock Hill South Carolina 29730
- ☐ Mail-Meds Clinical Pharmacy – 1911 Hampton Street, Columbia, SC 29201
- ☐ MedExpress Pharmacy/Avita Drugs – mail order pharmacy located in Salisbury, NC
- ☐ ProCare Pharmacy Direct/CVS Specialty – 3250 Harden St Ext. Suite 300, Columbia, SC 29205
- ☐ Spartanburg Regional Health Services/Medical Group of the Carolinas Infectious Disease – 101 E. Wood Street, Suite 410, Spartanburg, SC 29303

My signature below indicates my agreement to use the pharmacy selected above:

_____ _____

Applicant/Enrollee Signature Date

Instructions for Completing
INSURANCE ASSISTANCE PROGRAM (IAP)
PHARMACY SELECTION FORM

Purpose: This form will be used to provide relevant information to enroll applicants/enrollees in an DAP/IAP-contracted pharmacy. It is to be used for IAP only. This form is not for DDP or MAP. DDP and MAP applicants/enrollees must use a specific mail order pharmacy.

Instructions:

I. Applicant/Enrollee Information

DAP ID: Enter the applicant/enrollee's DAP ID, if available.

Name: Enter the applicant/Enrollee's Last, First, and Full Middle Name.

Date of Birth: Enter the applicant/Enrollee's Month and Year of birth.

Social Security Number: Enter the last four digits of the applicant/enrollee's Social Security Number.

II. Pharmacy Selection

A. Select if the applicant/enrollee's insurance requires the use of a specific pharmacy (example: Medco Mail Order, Caremark Mail Order, etc.). Indicate the name of the pharmacy the insurance requires the applicant/enrollee to use.

B. Select if the applicant/enrollee is able to use the pharmacy of their choice and would like to be enrolled with an DAP-IAP contracted pharmacy (see form for list of pharmacies).

Applicant/enrollee must sign and date the form.

Office Mechanics

Protected Health Information: This form contains Protected Health Information (PHI) and should be stored and/or disposed in accordance with the Provider's privacy policy. Appropriate forms of storage include but are not limited to: 1) in imaged format and secured in the electronic health record (EHR) system, 2) in paper format in each applicant/ enrollee's secure chart/file, 3) shredded in accordance with your organization's privacy policy. This record of disclosure must remain available for a six (6) year retention period.

Completed pharmacy enrollment forms must be submitted into Provide Enterprise by Case Manager or mailed to:

SC Insurance Assistance Program
2100 Bull Street
Columbia, SC 29201