Department of Public Health Sexually Transmitted Diseases Programs

2019 Medication Enrollment Agreement- STD

Completed forms can be EMAILED TO: DPH.TB-STDDRUGS@ct.gov

ORGANIZATION INFORMATION

Name:	***Federal Employer Tax ID***

AUTHORIZING OFFICIAL

Instructions: *This person must be someone who can contractually bind the Participant and has an oversight role that allows them to ensure compliance with the rules and requirements of the CT DPH STD 340B Program, e.g. Medical Director, Nursing Director, Health Director, CEO or COO.*

Last Name, First, MI:

Title:

ORGANIZATION FACILITIES

Instructions: *List below each facility (with a different address) covered by the federal tax ID listed above that will be using medications provided by CT DPH STD 340B Program. A "TB and STD Medication Facility Profile" needs to be completed for EACH facility address.*

FacilityName	Address	City	State	Zip

AGREEMENT

I. The Organization identified above agrees to:

A. General Requirements

1. Comply with Connecticut Department of Public Health Sexually Transmitted Diseases 340B Program Covered Entity Requirements, as periodically amended.
2. Annually submit a TB and STD Medication Facility Profile for each facility location that uses STD 340B medications provided by CT DPH. This profile should be re-submitted within 7 business days of a facility address change, facility closure or change in provider.
3. Maintain a copy of all records related to CT DPH STD 340B Program provided medications under this agreement for a minimum of 3 years. If requested, copies will be made available to DPH for review.
4. Maintain confidentiality of patient information according to state and federal laws, including HIPAA regulations, 45 C.F.R. § 160.101 et seq.
5. When utilizing the DPH Public Health Laboratory, submit all specimens with patient name and date of birth (no special unique identifiers).
6. Label drugs appropriately for the specific patient, as needed. The CT DPH STD 340B Program provides medication but does not dispense or label medication for specific patients.
7. Not engage in, and have procedures in place to prevent "fraud" or "abuse" as those terms are defined in the Medicaid regulations at 42 C.F.R. § 455.2, as periodically amended.
8. Upon termination of this Agreement, properly return any unused medication as directed by the Department.

B. Additional Requirements

Treatment

Adhere to the Centers for Disease Control and Prevention (CDC) STD treatment guidelines for treatment schedules, dosage and contraindications, as periodically amended, unless, in the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the patient. The guidelines are available at https://www.cdc.gov/std/tg2015/default.htm

Reporting

Report all patients diagnosed and treated with chlamydia, gonorrhea or syphilis using the STD-23 form. https://portal.ct.gov/DPH/Communications/Forms/Forms

II. Termination. The Department or Organization may terminate this agreement at any time by providing the other party with written notice thereof.

By signing this form, I certify that I am authorized to sign on behalf of the organization identified above and that all providers in the Organization have read and will be obligated to comply with the foregoing provisions and that we will abide by the "Connecticut Department of Public Health Sexually Transmitted Diseases 340B Program Covered Entity Requirements," as periodically amended.	
Authorizing Official (print):	
Signature:	Date: