EXAMPLE

MEMORANDUM OF UNDERSTANDING
BETWEEN
HEALTH DEPARTMENT
AND
PHARMACY

WHEREAS, ***Pharmacy*** will provide Buprenorphine/Naloxone for Health Department Medication Assisted Treatment patients free of charge. All prescription costs for Buprenorphine/Naloxone will be paid for by ***Health Department*** on behalf of the patient (while funding is available). This is in an effort to alleviate the financial burden Medication Assisted Treatment has had on the residents of ***X County***.

WHEREAS, this initiative is not indefinite as it is addressing immediate needs created by the Opioid Crisis and funds are limited. This agreement shall be in place for eleven months effective *July 1, 2020* and terminate on *May 31, 2021* or before if allocated funds have been depleted.

This MEMORANDUM OF UNDERSTANDING is hereby made and entered into by and between ***Health Department***, hereinafter referred to as ***HD*** and ***Pharmacy***, hereinafter referred to as ***RX***.

I. PURPOSE:

The purpose of this Memorandum of Understanding (MOU) is to establish a mutually agreeable framework for fulfilling Buprenorphone/Naloxone prescription on behalf of ***HD*** Medication Assisted Treatment patients and getting ***RX*** a timely reimbursement.

II. STATEMENT OF MUTUAL BENEFIT AND INTERESTS:

The parties in this MOU agree that it is in the communities' best interest to support the mission of ***HD*** as both parties work to support *X County* Residents.

III. TERM:

This MOU will be effective from the date the agreement is executed — the effective date of *July 1*, *2020* through the tentative completion date of *May 31, 2021*.

IV. ROLES AND RESPONSIBILITIES:

1. RX Shall:

a. Prescription for Buprenorphine/Naloxone from ***HD*** for an insured patient
   i. Fill their prescription per their own policies and procedures
   ii. The patient is responsible for the initial $20 of their prescription related co-payments/out-of-pocket cost
   iii. ***HD*** will pay the remaining portion of the patient's copayment/ out-of-pocket expense.

b. Prescription for Buprenorphine/Naloxone from ***HD*** for an uninsured patient
   i. Fill their prescription per their own policies and procedures and as written
   ii. The patient will not be charged for this prescription as ***HD*** will pay ***RX*** on behalf of the patient
   iii. Fill their prescription with the most affordable generic when possible

c. Reimbursement Request
   i. Send a monthly itemized invoice to ***HD*** at [address]
   ii. Itemized invoice should include: The date the prescription was filled, the patient's name, the quantity, cost per prescription, and total monthly cost.
   iii. Send all monthly invoices with "Attention: Name"

1. Send all reimbursement requests by the 10th of the following month. Ex. August's invoice must be sent by the 10th of September

EXAMPLE

d. Buprenorphine/Naloxone cost
i. Charge **HD** the current price for this medication
ii. *At the time of this agreement a 30 count of generic films cost $175.00 and a 30 count of tablets cost $90.00*
iii. Change their prescription fees as necessary based on their distributor costs
iv. Notify [Name] at ***HD*** when the prescription cost changes
e. Record Retention
i. All records related to this agreement must be retained for five years
2. ***HD*** Shall:
a. Medication Assisted Treatment Patients with insurance
i. Inform patients they are allowed to fill their prescription at the pharmacy of their choice
ii. Inform patients they are responsible for up to the initial *$20* of their associated copayment/ out-of-pocket cost based on their insurance and that ***HD*** will pay the remaining portion of the patient's copayment/ out-of-pocket expense
b. Medication Assisted Treatment Patients without insurance
i. Inform patients they are allowed to fill their prescription at the pharmacy of the choice
ii. Inform patients that while funds are available they can receive their Buprenorphine/Naloxone free of charge and paid in full by ***HD***
c. Reimbursement to ***RX***
i. Process all invoices from ***RX*** in a timely fashion
1. *X County* issues checks once a week
2. Mail all payment to: [***RX*** Name & Address]
ii. Buprenorphine/Naloxone Cost:
1. Pay the current cost for any generic prescription or pay for the prescription as written by the ***HD*** provider
iii. Record Retention
1. All records related to this agreement must be retained for five years

V. GENERAL TERMS AND CONDITIONS:

1. This MOU may be terminated by either party for any reason at any time upon giving forty-five days written notice of such termination

VI. PRINCIPAL CONTACTS:

Health Department
[Address]
[Phone #]
[Signees Name]
[Signees Title]
[Signees email address]

Pharmacy
[Address]
[Phone #]
[Signees Name]
[Signees title]
[Signees email address]

VII. SIGNATURES

By signing below, the parties to this MOU certify that the individuals listed in this document as representatives of the parties hereto are authorized to act in their respective areas for matters related to this agreement.

Health Department
Signature
Date

Pharmacy
Signature
Date