



Pharmacy Select

The leading generic purchasing program, used by more than 7,000 pharmacies.

Pharmacy Select Purchasing Application

The _____ of _____,
(Pharmacy) (City, State)

hereinafter referred to as "PHARMACY" does hereby make application to the PHARMACY PROVIDER SERVICES CORPORATION hereinafter referred to as "PPSC" for access to the PPSC PHARMACY SELECT GROUP PURCHASING CONTRACT. PHARMACY does hereby acknowledge that PPSC is engaged in the business of negotiating for the purchase of pharmaceuticals and other merchandise from manufacturing and distributing firms hereinafter referred to as "MANUFACTURERS" on the behalf of affiliated pharmacies.

1. PHARMACY shall maintain a valid permit and DEA Certificate to operate a pharmacy in the jurisdiction where PHARMACY engages in business and agrees to provide reasonable evidence of such upon request.

2. PHARMACY recognizes that PPSC shall provide THE PHARMACY SELECT GROUP PURCHASING CONTRACT through AMERISOURCEBERGEN, the sole Prime Vendor Wholesaler. This contract is adopted as an automatically substituted secondary wrap-around contract to the AMERISOURCEBERGEN Pro Generics Contract.

3. PHARMACY recognizes that it has the right, but not the obligation to purchase contractually awarded pharmaceuticals and other merchandise for its own use from the PPSC PHARMACY SELECT GROUP PURCHASING CONTRACT available only through AmersourceBergen.

4. PHARMACY authorizes PPSC, or its designated agent, to negotiate and enter into agreements on its behalf for the purchase of pharmaceuticals and other merchandise.

5. PHARMACY authorizes PPSC, or its designated agent, to obtain copies of all records in possession of the Prime Vendor Wholesaler including but not limited to those reflecting product velocity movement, controlled substance purchases, inventory management, item sales analysis, and other such data pertaining to PHARMACY, that are captured or generated by AmersourceBergen in regard to their participation in the PHARMACY SELECT GROUP PURCHASING CONTRACT.

PHARMACY NAME

STREET ADDRESS

CITY, STATE, ZIP

AREA CODE / TELEPHONE NUMBER/ FAX NUMBER

BOARD OF PHARMACY PERMIT **DEANUMBER** **NCPDP#**

FEDERAL TAX IDENTIFICATION # **E-MAIL ADDRESS**

PRINT NAME **SIGNATURE**

TITLE **DATE**

AMERISOURCEBERGEN _____
(DISTRIBUTION CENTER CITY/STATE)

AMERISOUCEBERGEN CUSTOMER #: _____