Fields of Opportunities

STATE OF IOWA

MASTER AGREEMENT

Contract Declaration and Execution

EFFECTIVE BEGIN DATE: 05-01-2008
EXPIRATION DATE: 04-30-2009
PAGE: 1 of 3

VENDOR:
MCKESSON HVOC, INC.
BANK OF AMERICA
12748 COLLECTIONS CTR DR
CHICAGO, IL 60693
USA

VENDOR CONTACT:
Tom Horner
PHONE: 319-360-3207 **EXT:**
EMAIL:

ISSUER:
JEANETTE CHUPP
PHONE: 515-281-6288
EMAIL: Jeanette.Chupp@iowa.gov

FOB FOB Dest, Freight Allowed

Contract For: Pharmaceutical Distribution thru ServiShare

The parties agree to comply with the terms and conditions on the following attachments which are by this reference made a part of the Agreement.
Attachment 1: General Terms and Conditions for goods contracts posted at: http://das.gse.iowa.gov/terms_goods.pdf
Attachments 2. - 3. are on file with the Dept. of Administrative Services, GSE.
Attachment 2: Cooperative Purchasing Agreement pursuant to 8A.311(A) Iowa Code - 2005 Supplement
Attachment 3: HPPI / Provista Pharmacy Program Participation Form

To request a Pharmacy Program Participation Form, contact Amber Fisher at ServiShare: phone 515-288-1955 or e-mail: fishera@ihaonline.org

Local McKesson Drug Representative: Ted Walz at phone 800-804-4584 X 4154 or fax 402-592-9147.

McKesson Acount Manager: Tom Horner at Phone 319-360-3207 or FAX 319-393-6560

Note: This Agreement / Vendor Record provides for "EFT Payments".

RENEWAL OPTIONS

FROM 05-01-2009 **TO** 04-30-2010
FROM 05-01-2010 **TO** 04-30-2011
FROM 05-01-2011 **TO** 04-30-2012

AUTHORIZED DEPARTMENT
ALL

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR	STATE OF IOWA
CONTRACTOR'S NAME (If other than an individual, state whether a corp., partnership, etc.	AGENCY NAME Dept. Administrative Services
BY (Authorized Signature) Date Signed	BY (Authorized Signature) Jeanette Chupp Date Signed May 23, 2008
Printed Name and Title of Person Signing	Printed Name and Title of Person Signing Jeanette Chupp
Address	Address Hoover Bldg, Des Moines, Iowa

STATE OF IOWA

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LINE NO.	QUANTITY / SERVICE DATES	UNIT	COMMODITY / DESCRIPTION	UNIT COST / PRICE OF SERVICE
1	0.00000		269 **DRUGS AND PHARMACEUTICALS** Pricing per Individual Facility Authorized Distribution Agreement.	$0.000000 $0.000000
2	0.00000		271 **DRUG AND FEEDING ADMINISTRATION, INFUSION, AND IRRIGATION EQ** Pricing per Individual Facility Authorized Distribution Agreement.	$0.000000 $0.000000
3	0.00000		27176 **Premixed Pharmaceutical Solutions** Pricing per Individual Facility Authorized Distribution Agreement.	$0.000000 $0.000000
4	0.00000		96286 **Transportation of Goods and Other Freight Services** Pricing per Individual Facility Authorized Distribution Agreement.	$0.000000 $0.000000

STATE OF IOWA

MASTER AGREEMENT

Contract Declaration and Execution

TERMS AND CONDITIONS

Terms & Conditions Goods

The parties agree to comply with the terms and conditions on the following web site which are by this reference made a part of the Agreement.

General Terms and Conditions for goods contracts are posted at: http://das.gse.iowa.gov/terms_goods.pdf

ServiShare
Contract Data Sheet

2411D

Supplier:	McKesson 1 Post Street, 30th Floor San Francisco, CA 94104
Product/Services:	Pharmaceutical Distribution
Place Orders:	Local rep: Ted Walz telephone 800-804-4584, X4154 fax 402-592-9147
Payment address:	McKesson 7009 S. 108th Street LaVista NE 68128 Or McKesson 1315 N. Chouteau Trafficway Kansas City, MO 64120
Contract Period:	May 1, 2006 through April 30, 2011
Price/Discount:	Pricing available to members on HPPI web site
Payment terms:	Per individual distribution agreement
Delivery:	Per customer request
Special Conditions:	Authorized distributor under 2411 ServiShare agreement

HPPI

Pharmacy Program Participation Form

_____ Located in _____,

Facility Name City & State

a Member of HPPI, desires to purchase pharmaceuticals, over-the-counter drugs, health and beauty aids, medicines, drugs ,and goods related to the use thereof (collectively "Pharmaceuticals") through HPPI's Pharmacy Program for its own use.

Instructions when choosing AmerisourceBergen, Cardinal, McKesson, Morris & Dickson, Burlington Drug, Dakota Drug, or H.D. Smith as your authorized distributor:

1. Designate primary distributor:

☐	AmerisourceBergen	National Coverage
☐	Cardinal	National Coverage
☐	McKesson	National Coverage
☐	Burlington Drug	Regional – servicing most of New England (Vermont, New Hampshire, southern Maine, northern Massachusetts, part of upstate New York)
☐	Dakota Drug	Regional – servicing North Dakota, Minnesota, South Dakota, Eastern Montana, and parts of Iowa
☐	H.D. Smith	Regional – Illinois (including Chicago and surrounding area), metro NYC/New Jersey, North Texas/Oklahoma, southern California/Arizona, and Florida
☐	Morris & Dickson	Regional – Louisiana, Mississippi, Alabama, Texas, Oklahoma, parts of Missouri, Illinois, Tennessee, and expanding into Georgia and part of Florida

We have also selected this distributor as our backup:

BACKUP DISTRIBUTOR NAME:

2. Evaluate and enroll in the distributors optional incentive programs (see Pharmacy Distribution Launch Package).

DISTRIBUTOR	PROGRAMS
AmerisourceBergen	• 3-year Commitment • 5-year Commitment • 7-year Commitment **Note: If you are choosing AmerisourceBergen you must complete the AmerisourceBergen Group Declaration Form and the AmerisourceBergen Letter of Participation**
Cardinal	• EFT Payment • IDN centralized billing and payment incentive • Prime Vendor Incentive program • 3-year Commitment

McKesson	• EFT Payment • Return Goods Policy Incentive
Burlington Drug	• IDN centralized billing and payment incentive
Dakota Drug	• EFT Payment
H. D. Smith	• EFT Payment • IDN centralized billing and payment • 3-year Commitment • 5-year Commitment • 7-year Commitment
Morris & Dickson	• EFT Payment • IDN centralized billing and payment incentive • 3-year Commitment • 5-year Commitment • 7-year Commitment

3. Complete the new customer credit application required by your new distributor.
4. Fax forms to HPPI, attention Member Services at (972) 910-6604.

(Note: Standard Terms & Conditions require 45 days notice to the pharmaceutical Suppliers to add a new participant to a purchasing agreement.)

Health Care Organization (HCO):* _____

Address: _____

City/State/Zip: _____

DEA No.: _____ Class of Trade: _____

*For integrated delivery networks (IDNs) or integrated health care systems (IHCS), please list members on the following page. Provide additional pages if necessary.

Director of Pharmacy or Other Contact Name: _____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

Submitted By:		Phone No.:	
Member ID No.:		Date:	

Copy and fax to: HPPI Member Services at (972) 910-6604

Problems? Contact us at (888) 538-4662 or HPPICustomerService@hppigpo.com.

IDN / IHSC Member Listing

HCO Name:	DEA No.:
Address:	
City, State, ZIP:	
Pharmacy Contact Name:	
Title:	
Telephone, Fax, E-Mail Address:	

HCO Name:	DEA No.:
Address:	
City, State, ZIP:	
Pharmacy Contact Name:	
Title:	
Telephone, Fax, E-Mail Address:	

HCO Name:	DEA No.:
Address:	
City, State, ZIP:	
Pharmacy Contact Name:	
Title:	
Telephone, Fax, E-Mail Address:	

HCO Name:	DEA No.:
Address:	
City, State, ZIP:	
Pharmacy Contact Name:	
Title:	
Telephone, Fax, E-Mail Address:	