Pharmacy User Access Authorization Form

PHARMACY INFORMATION:

Pharmacy Name

Pharmacy Mailing Address

Name of Chain or PSAO

Phone Number

Fax Number

NCPDP Number

NPI Number

USER INFORMATION:

Please identify the individual(s) who will perform services on the MirixaPro^{SM} platform on behalf of your pharmacy. These "Authorized User(s)" will have access to your pharmacy's cases and patient data. **YOUR PHARMACY ASSUMES RESPONSIBILITY FOR THE ACTIONS OF ALL AUTHORIZED USERS.** Note that if any Authorized User stops performing services on behalf of your pharmacy (*e.g., if the user is no longer employed at the pharmacy*), you must notify Mirixa Support (**support@mirixa.com**) immediately so that the user's account may be deactivated.

Authorized User Information (All Accounts)	Additional Privileges *		
Mirixa will create a MirixaPro account for each user listed below. Typically, Authorized Users are licensed pharmacists, pharmacy students, or pharmacy technicians assisting with patient care services.	Is this user a service provider entitled to authorize billing for health care services? (Yes/No)	Should this user be able to add or manage user accounts on behalf of pharmacy? (Yes/No)	Does this user have the power to sign contracts on behalf of pharmacy? (Yes/No)
Name Title Email Address			
Name Title Email Address			
Name Title Email Address			

* Saying "yes" in these boxes provides a user with privileges that do not exist for a "basic" account. Generally, pharmacists are entitled to authorize billing for health care services. Most pharmacies appoint one senior staff member to manage all user accounts on behalf of the pharmacy. Other users, including technicians and students, maintain "basic" accounts to allow them to assist with case scheduling, data entry, and other important functions.

An owner or manager should sign this form to approve other pharmacy staff to become an Authorized User(s). You cannot identify yourself as an Authorized User unless you are the pharmacy owner or highest executive. **By signing below, you are attesting that you have the legal authority to sign on behalf of your pharmacy and to identify Authorized Users of the MirixaPro platform.**

Signature: _____   Print Name: _____

Title: _____   Date: _____

PLEASE FAX THIS COMPLETED FORM TO MIRIXA CORPORATION AT (703) 865-2198
For additional assistance, contact Mirixa Support at (866) 218-6649 or **support@mirixa.com**