

# Prime Therapeutics Provider Manual



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# Introduction to Prime Therapeutics LLC

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Prime Therapeutics LLC (Prime) is a pharmacy benefit manager (PBM) company that provides comprehensive pharmacy management solutions to Prime's clients. Some of Prime's services include:

- Pharmacy networks
- Formulary management
- Pharmacy communication
- Drug utilization review (DUR)
- Clinical programs
- Physician education
- Claims processing

Prime encourages the use of safe and cost-effective therapies for clients' members while maintaining a valued relationship with pharmacies participating in Prime's network. Prime promotes the use of local programs to meet the needs of Covered Persons and Benefit Sponsors and encourages the important connection a pharmacist maintains with his or her patients.

Prime manages pharmacy networks to provide Prescription Drug Services for its clients through Prime's online point-of-sale (POS) system. The POS system gives Participating Pharmacies real-time access to patient eligibility, drug coverage information, drugs requiring prior authorization and DUR information.

Prime is committed to doing business with integrity and in accordance with all applicable federal, state and local laws. Prime has adopted a compliance program and code of conduct which includes policies and procedures to avoid potential conflicts of interest and fraud, waste and abuse. Prime strongly encourages all Participating Pharmacies to adopt appropriate compliance programs; codes of conduct; fraud, waste and abuse programs; and conflict of interest policies and procedures.

## Provider Manual

The purpose of this Provider Manual ("Manual") is to explain Prime's administrative and compliance policies and procedures. The Manual is incorporated into the Prime Therapeutics Pharmacy Participation Agreement ("Agreement"). This Manual will be updated as necessary at Prime's sole discretion. Prime posts the most current version of the Provider Manual on its website at [PrimeTherapeutics.com](http://PrimeTherapeutics.com).

Additionally, relevant instructions, notices, information and supplements or changes to the Manual are posted on the Prime website. Consult [PrimeTherapeutics.com](http://PrimeTherapeutics.com) for up-to-date information and processing instructions.

All capitalized terms that are otherwise not defined in this Manual refer to those defined in the Agreement.

### **Important:**

**This Manual applies to Commercial, Medicare and Medicaid business.**

# Section 1: Prime Contact Information

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## Prime Mailing Address

If you would like additional information, contact Prime at:

**Prime Therapeutics LLC**  
**P.O. Box 64812**  
**St. Paul, Minnesota 55164-0812**

## Prime Contact Center

**800.821.4795**

The Prime Contact Center has dedicated staff to assist pharmacies with contract requests and processing questions or concerns. Prime's representatives are available 24 hours a day, 365 days a year.

## Prime's Website

Visit Prime's website ([PrimeTherapeutics.com](https://www.PrimeTherapeutics.com)) for the following information:

- [Payer Specification Sheets](#)
- [Medicare Plan-Specific Reference Guides](#)
- [Exception Request Forms](#)
- [Formulary Information/Formulary Updates](#)
- [Pharmacy Remittance Request](#)
- [Prime Perspective Newsletters](#)
- [Fraud, Waste and Abuse Training, Requirements and Certification Materials](#)
- [FWA Referral Form](#)
- [Plan Announcements](#)
- [Network Request Form General Information and Services](#)
- [835 Electronic Remittance Request Form](#)
- [Common Billing Errors](#)
- [Exhibit C: Minimum Performance and Service Criteria for Medicare Programs](#)
- [Exhibit C-1: Minimum Performance and Service Criteria for Medicare Programs LTC](#)
- [Medicare Part B vs. Part D Coverage Issues](#)
- [Pharmacy Audit Appeal Form](#)

## Section 1: Prime Contact Information (Continued)

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### Fraud, Waste and Abuse

We each have an obligation to help protect and maintain the integrity of the health care system by promptly reporting suspicious activity. Pharmacies participating in Prime's Medicare Networks must attest on an annual basis to the completion of Compliance and Fraud, Waste and Abuse training required by the Centers for Medicare and Medicaid Services (CMS). For your convenience, training and the Certification of Compliance form are posted on Prime's website.

If you suspect fraud, waste or abuse (FWA), whether by a Covered Person, Prescriber, another Participating Pharmacy, or anyone else, notify Prime by calling Prime's FWA Hotline at **800.731.3269**, emailing [reportfraud@primetherapeutics.com](mailto:reportfraud@primetherapeutics.com), calling Prime's 24-hour Anonymous Compliance Hotline at **800.474.8651** or mail at:

**Prime Therapeutics LLC**  
**Attn: Compliance Officer**  
**P.O. Box 64812**  
**St. Paul, MN 55164-0812**

Participating Pharmacies are expected to exercise due diligence to ensure prescriptions are valid. For example, upon receipt of a prescription order that appears potentially altered or forged, contact the Prescriber to validate the prescription. Remain mindful of and promptly report potential fraud, waste or abuse.

Examples of fraud, waste, abuse include:

- **Misrepresentation of status:** A Covered Person or other individual misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive a drug benefit; or an individual who no longer has prescription drug coverage attempts to use his/her identity card to obtain prescriptions.
- **Identity theft:** An individual uses another person's Medicare or health insurance card to obtain prescriptions.
- **Illegal resale of drugs:** A Covered Person falsely reports loss or theft of drugs or feigns illness to obtain drugs for illegal resale.
- **Prescriber shopping:** A Covered Person consults a number of Prescribers for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs.
- **Script mills:** A Prescriber writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for Covered Persons that are not theirs. These scripts are usually written, but not always, for controlled drugs for illegal sale, and might include improper payments to the Prescriber.
- **Theft of Prescriber's DEA number or prescription pad:** Prescription pads and/or DEA numbers stolen from Prescribers illegally which are used to write prescriptions, often for controlled substances or other medications which typically are either abused or sold on the black market.
- **Inappropriate billing practices:** Inappropriate billing practices occur when pharmacies engage in billing practices which include, but are not limited to:
  - › Incorrect billing for secondary payers to receive increased reimbursement;
  - › Billing for non-existent prescriptions;
  - › Billing multiple payers for the same prescriptions, except as required for coordination of benefits transactions;
  - › Billing for brand drugs when generic drugs are dispensed;
  - › Billing for non-covered prescriptions as covered items;
  - › Billing for prescriptions that are never picked up (i.e. not reversing claims that are processed when prescriptions are filled but never picked up);
  - › Billing based on "gang visits," e.g. a pharmacist visits a Long-Term Care Facility and bills for numerous pharmaceutical prescriptions without furnishing prescriptions to the Covered Person;
  - › Inappropriate use of product select codes (PSC);

## Section 1: Prime Contact Information (Continued)

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- › Prescription splitting to receive additional dispensing fees; or
- › Drug diversion.
- **Prescription drug shorting:** A pharmacy provides less than the prescribed quantity and intentionally does not inform the Covered Person or make arrangements to provide the balance but bills for the fully-prescribed amount.
- **Bait and Switch pricing:** A pharmacy leads a Covered Person to believe that a drug will cost one price, but at the point-of-sale, the Covered Person is charged a higher amount.
- **Prescription forging or altering:** Existing prescriptions are altered by a Covered Person without the Prescriber's permission to increase the quantity or number of refills.
- **Dispensing expired or adulterated prescription drugs:** Pharmacies dispense drugs that are expired or have not been stored or handled according to the manufacturer or FDA requirements.
- **Prescription refill errors:** A pharmacy provides a different number of refills than what was prescribed by the Prescriber.
- **Illegal remuneration schemes (kickbacks):** A pharmacy is offered, paid, solicits, or receives unlawful remuneration to induce or reward it to switch Covered Persons to different drugs, influence Prescribers to prescribe different drugs, or steer Covered Persons to plans.
- **TrOOP manipulation:** Manipulation of true out-of-pocket (TrOOP) costs by the pharmacy to either push a Covered Person through the coverage gap so that the Covered Person can reach catastrophic coverage before they are eligible, or to keep a Covered Person in the coverage gap so that catastrophic coverage is never realized.
- **Failure to offer negotiated prices:** A pharmacy's failure to offer a Covered Person the negotiated price of a drug.

# Section 2: Claims Processing

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## General Information

### Online Claims Submission

- The Participating Pharmacy is required to electronically submit all claims to Prime for all Prescription Drug Services provided to a Covered Person including situations where no payment from Prime is due.

### Online Availability

The online system is generally available for claims processing 24 hours a day, 365 days a year.

### Claim Formats

- Point-of-sale (POS) claims must be submitted in the current NCPDP format or current industry-utilized version.
- Batch claims must be submitted in the NCPDP Batch format or current industry-utilized version.
- The Universal Claim Form (UCF) must be submitted for paper claim submissions. UFC's are available on the NCPDP website at [www.ncpdponline.org](http://www.ncpdponline.org).

For a complete list of required and/or situational processing requirements, refer to Prime's Payer Specification Sheets on [Prime's website](#).

In order for Prime to assist Participating Pharmacies with claims adjudication, email your unique processing codes CONDOR CODES/INPUT CODES to [pharmacyops@primetherapeutics.com](mailto:pharmacyops@primetherapeutics.com)

### Claims Processing Guidelines

The following fields are required:

- Bank identification number (BIN)
- Processor control number (PCN)
- Member ID
- Date of birth (DOB)
- Usual and customary charge (U&C)

Benefit Sponsors may require additional fields. The Participating Pharmacy must review all POS messaging for processing information and Benefit Payer Specification Sheets for software set up.

### Medicare Reference Materials

The following documents are available on [Prime's website](#):

- [Medicare Processing Guide](#)
- [PDP Contact Reference Guide](#)
- [MA-PD Contact Reference Guide](#)
- [Employer Groups Contact Reference Guide](#)
- [Medicare Part D Payer Specification Sheet](#)
- [Supplemental to Medicare Part D Payer Specification Sheet](#)
- [Medicare Prescription Drug Coverage and Your Rights \(CMS requires this Part D member notice to be posted at the pharmacy\)](#)

## Eligibility

### Member ID Card

The Participating Pharmacy shall require a Covered Person to produce a member identification (ID) card prior to providing a Prescription Drug Service. The member ID card does not ensure a Covered Person's eligibility. If a Covered Person does not have a member ID card and the Participating Pharmacy is unsure of eligibility, contact Prime's Contact Center to obtain accurate member information prior to dispensing a product or processing a claim.

### Covered Person Eligibility

A Covered Person's eligibility can be verified through the POS system during claim adjudication or by contacting the Prime Contact Center. Unless expressly allowed in this Manual, never should a Covered Person whose eligibility has been verified:

1. Be denied a Prescription Drug Service (subject to pharmacist's professional judgment)
2. Be asked to pay more than is due under the terms of the Agreement
3. Be asked to pay cash and submit a paper claim

## Section 2: Claims Processing (Continued)

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### Same Gender Multiples

When processing claims for multiples of the same gender with the same birth date and same medication, use the following procedure:

1. Process the first claim as usual
2. Attempt to process the second claim as usual
3. If the second claim rejects, contact the Prime Contact Center to verify the multiple-birth eligibility flag has been set

### Medicare E1 Eligibility Query

The E1 Eligibility Query is a transaction utilized by CMS to assist pharmacies in determining Part D enrollment and payer order for a given dual eligible Covered Person when this information is not known. Covered Persons may not know their Medicare ID numbers or their coverage payment order. This transaction is specifically designed to assist pharmacists in these types of situations. Note that these queries are to be submitted to the TrOOP facilitator, Relay Health, and not to Prime or the Benefit Sponsors.

Additional information on E1 Transactions can be found at <https://medifacd.relayhealth.com/>.

### Best Available Evidence (BAE)

Medicare members who are eligible for Low Income Subsidy (LIS) are enrolled in the claim system with the appropriate LIS copay level. In the event the claims system does not show the correct LIS status for the Covered Person, the Participating Pharmacy is required by Medicare to accept BAE when presented at the point of sale. Medicare also requires Participating Pharmacies to assist Covered Persons who believe they are eligible for LIS, but do not have BAE documentation.

For Covered Persons with supporting BAE documentation:

- The Participating Pharmacy must call Prime's Contact Center to request an immediate LIS status update in the claims system.
- The Participating Pharmacy may submit the claim once the claim system is updated with LIS status.
- The Participating Pharmacy must fax a copy of the Covered Person's supporting BAE documentation to the Prime Contact Center at **402.970.2515**.
- Prime will forward the BAE documentation to the Part D Sponsor, who will then work with CMS to update the Covered Person's LIS status in CMS' system.

For Covered Persons without supporting BAE documentation:

- The Participating Pharmacy should determine if the member has less than three days of medication remaining (an "immediate need").
- The Participating Pharmacy should contact Prime's Contact Center to begin the process of updating the enrollee's LIS status; the request must indicate an immediate or non-immediate need.
- Prime will contact the Part D Sponsor, who will complete the BAE Assistance Worksheet and submit to CMS to validate and/or update the Covered Person's LIS status in CMS' system.
- CMS will update the Covered Person's LIS status within one business day for immediate needs.

## Submitting the Claim

### Bank Identification Number (BIN) and Processor Control Number (PCN)

A bank identification number (BIN) is required when adjudicating claims through the point-of-sale (POS) system. A list of the BINs and PCNs used to adjudicate claims through Prime's POS system is listed on [Prime's website](#).

### National Provider Identifier (NPI)

- **Pharmacy NPI** – All online claims must be submitted with the Pharmacy NPI. Online claims submitted with the Pharmacy NCPDP number will reject.

## Section 2: Claims Processing (Continued)

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- **Prescriber NPI** – Until further notice, Prime will continue to accept the Prescriber’s DEA number or NPI number. Prime prefers the Prescriber NPI as the submitted value, when available. See Prime’s Payer Specification Sheets, as some Benefit Sponsors may require the submission of the Prescriber NPI. Use of a dummy provider number is prohibited.

### **Documentation**

Verbal changes and clarifications to the Prescriber’s prescription order must be documented on the original hard copy or electronically noted in the pharmacy’s online system prior to dispensing. Electronic documentation must be noted prior to dispensing and have a system assigned user, date and time stamp in order to take the place of hard copy documentation. When additional refills are ordered, a new prescription number must also be assigned and appropriately documented on a hard copy.

### **Days Supply**

The Participating Pharmacy must submit the number of consecutive days supply the prescription product will last that falls within the Covered Person’s benefit. Future refills may be rejected, and audit chargebacks may be assessed, if the days supply is inaccurately submitted.

For prescription products that cannot be broken (e.g., inhalers), where the smallest unit available exceeds the benefit days supply, the Participating Pharmacy must submit the maximum days supply allowed under the benefit.

*Example:* Covered Person’s benefit allows a 34-day supply. One inhaler will last 40 days. The Participating Pharmacy must bill the inhaler as a 34-day supply.

In situations where one unit does not maximize the benefit’s days supply (e.g., inhalers) the Participating Pharmacy must submit only the quantity that falls within the benefit.

*Example:* Covered Person’s benefit allows a 34-day supply. One inhaler will last 28 days. The Covered Person receives one inhaler as a 28-day supply.

### **Accurate Quantity**

The quantity dispensed must be entered exactly as written. Submit quantities as metric quantity (including decimal points). The Participating Pharmacy must enter the exact metric decimal quantity on claims, without rounding up or down.

### **Dispensed Package Size/National Drug Code (NDC)**

When the Participating Pharmacy submits a claim for a Prescription Drug Service provided, the Participating Pharmacy must submit the NDC number for the original package size from which the Prescription Drug Service was dispensed. The quantity of the prescription drug dispensed shall comply with the dispensing limitations obtained through the online point-of-sale (POS) system.

Prescriptions may not be separated and dispensed by doses. If separate packaging is required, the Participating Pharmacy must use a duplicate label. For example, a dose required in school or adult care center should not be dispensed as a separate prescription.

### **Timely Filing**

The Participating Pharmacy agrees to submit all claims online within 90 days of the date of service.

### **Medicare e-Prescribing and Prescription Origin Code**

In the event the Participating Pharmacy participates in the Medicare electronic prescribing (“e-prescribing”) program by receiving or transmitting electronic prescriptions or prescription-related information, the Participating Pharmacy agrees to comply with applicable e-prescribing standards as established by CMS.

Regardless of whether a Participating Pharmacy is participating in e-prescribing all claims submissions must indicate the Prescription Origin Code, in order to facilitate CMS reporting and tracking of e-prescribe participation.

## Section 2: Claims Processing (Continued)

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### Requirements for Participating Pharmacies Contracted with 340B Covered Entities

Under the 340B Drug Pricing Program established by Section 340B of the Public Health Services Act, pharmaceutical manufacturers agree to charge at or below statutorily defined prices known as the 340B ceiling prices when selling to certain qualified entities. State Medicaid and Medicaid Managed Care Organization programs (collectively, Medicare Programs) cannot invoice a manufacturer for 340B drugs under the drug rebate program. Section 2501(c) of the Patient Protection and Affordable Care Act extended rebates under the drug rebate program to drugs dispensed to individuals enrolled with a Medicaid Managed Care Organization.

To view the specific claim processing requirements for Prime's Medicaid programs, please go to [Pharmacists/Medicare Programs](#)

### Compound Drugs Billing Guidelines

Participating Pharmacies must submit compound drugs through the Prime point-of-sale (POS) system using the following directions:

- Flag the compound as a compound drug in the pharmacy's system prior to adjudication.
- Submit the NDC of the most expensive legend ingredient per unit in the claim.
  - › Each product contained in the compound must have a valid NDC number.
- Submit the Final Product Quantity. The Final Product Quantity is the quantity of the finished compound product.
  - › i.e. For a liquid, submit the number of ml of the finished compound product. For capsules, submit the total number of capsules being dispensed.
- Submit the Total Ingredient Cost. The Total Ingredient Cost is, for each eligible ingredient used, multiply (the quantity used for the individual ingredient) and (the AWP for the individual ingredient according to the Pricing Source at the time of dispensing). Then, add all of the individual ingredient costs to submit as the Total Ingredient Cost.
  - › For Medicare, do not include any ingredient costs associated with an ineligible Medicare drug.
  - › Plan-excluded drugs and invalid NDCs are not eligible for reimbursement.
  - › Eligible ingredient costs do not include costs for labor, equipment, professional fees or flavoring.
- Maintain compound log documentation to document quantities and NDCs of the ingredients used to prepare the compound.

Prime has not instituted the multiple NDC compound submission function to adjudicate claims for compound medications. This functionality will be announced in *Prime Perspective* in the future and also will be available on [Prime's website](#).

Prime does not consider the following a compound drug and must not be submitted through the POS system as a compound drug:

- Reconstituted non sterile products, in which only water, alcohol or sodium chloride solution are added to the active ingredient (for example, children's antibiotic suspensions)
- Any prescription that is sub-divided into unit dose(s)
- Injectable drugs that are drawn into syringes for administration
- Any finished product that does not include a Federal Legend Drug as an ingredient
- Any compound that has an equivalent commercial form
- Any compound to which active ingredients are added that were not part of the prescription order
- Any compound that differs from the equivalent commercial form only by the addition of cosmetic agents or agents intended to produce a cosmetic effect
- Any finished product intended to address medical diagnosis (such as sugar-free products) where the member's medical diagnosis does not support need for the finished product

## Section 2: Claims Processing (Continued)

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Participating Pharmacies are expected to observe applicable state and federal law, relevant U.S. Pharmacopoeia (USP) Chapter Guidelines, professional standards and FDA communications when preparing and dispensing compound drugs. Evidence of unprofessional or unsafe compounding will be reported to the applicable State Board of Pharmacy, the FDA, and/or may result in termination of your Pharmacy Participation Agreement.

The following types of compound drugs are generally not covered by health plans and should not be submitted to Prime:

- Modified-release compounds
- Any compound that contains active ingredients not approved by the FDA
- A compound for which the stability is unknown at the time of dispensing or cannot be determined by reference of an USP-approved reference material
- Compound components, methods of administration, or other criteria that do not satisfy the definition of a Medicare drug
- Experimental/investigational items, products or services

### **General Insulin Benefits**

- A valid prescription must be on file for insulin dispensed to a Covered Person.
- Insulin should be dispensed within the days supply limits set by the Covered Person's Benefit Sponsor.
- Specific dosing directions must be documented at the time of dispensing. If sliding scale is used, the Participating Pharmacy must document maximum and minimum quantities at the time of dispensing. "Use as Directed" is not accepted.

### **Insulin Supplies**

- Unless indicated by the POS system, insulin syringes and needles are generally a covered benefit.
- A valid prescription is required for insulin syringes and needles to be dispensed to a Covered Person.
- Some Benefit Sponsors will waive the copayment for insulin supplies that are dispensed at the same time as insulin. In this situation, the insulin must be processed first.

### **Long-Term Care (LTC) and Home Infusion Therapy (HIT) Processing Guides**

Prime requires LTC and HIT Participating Pharmacies to submit patient residence fields as outlined on the [Payer Sheets](#).

### **Medicare Programs Coordination of Benefits (COB)**

COB claims for Medicare Programs should be processed on Prime's claims processing system. Participating Pharmacies must submit the primary claim to Prime electronically. After Prime adjudicates the claim, Prime will provide POS messaging that contains the claim transaction information and the Covered Person's supplemental coverage record if Prime is aware of other supplemental coverage. This POS messaging will generally accommodate multiple supplemental plans and include information required to process the supplemental claim(s).

Supplemental claims must be processed through a switch in order to correctly capture these transactions for true out-of-pocket (TrOOP) calculation purposes. This process is designed to function in real-time and to process all levels of payer submissions for a claim at the POS. When the primary payer or payer order information is not known or is in doubt, the pharmacist has the ability to send an E1 Eligibility Query to the TrOOP facilitator to determine proper payer order. Prime's Supplemental to Medicare Payer Specification Sheet is available on [Prime's website](#).

## Section 2: Claims Processing (Continued)

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### **Time Limits for Coordination of Benefits**

Effective January 1, 2011, the time limits for coordinating benefits with State Pharmaceutical Assistance Programs, other entities providing prescription drug service or other payers cannot exceed three years from the date on which the prescription for the Medicare drug was filled.

This does not affect time frames for Medicare secondary payer (MSP) prescription drug claims and the ability to recover amounts.

### **Medicare Parts A & B vs. D Claims Adjudication**

Medicare Part D excludes from coverage any drugs covered under Medicare Part A or Part B. Participating Pharmacies are responsible for ensuring that claims eligible for coverage under Part A or Part B are not adjudicated under Part D.

Participating Pharmacies that serve Long-Term Care (LTC) facilities are required to determine potential Part A eligibility by reviewing Part A eligibility information with their contracted LTC facilities. Participating Pharmacies should seek payment from the LTC facility for services for Covered Persons under a qualifying and covered Part A stay.

Prime provides POS messaging on certain claims that may be eligible for coverage under Medicare Part A or Part B depending on the Covered Person's circumstance. The Participating Pharmacy must take appropriate steps as necessary to ensure Part A and Part B eligible claim(s) are not adjudicated under Part D.

- During the claim adjudication, the Participating Pharmacy is prompted through messages to submit a prior authorization (PA) code for Part D adjudication. Claims not meeting the Part D requirements are to be billed to Part A or Part B, as appropriate.
- If the pharmacist cannot determine through the PA process whether a drug should be billed under Part A, Part B or Part D after talking with the Covered Person or Prescriber, then the Covered Person/Prescriber may submit a request for coverage determination.

Any claims adjudicated under the Part D benefit in error, due to Medicare Part A or Part B coverage shall be reversed by Prime. A Participating Pharmacy must promptly reverse the Part D claim(s) after determining that it was eligible for coverage under Part A or Part B, and refund any Part D cost-sharing collected from the Covered Person. Notwithstanding the Participating Pharmacy's obligation to reverse ineligible claims, at its discretion Prime may reverse ineligible Part D claims. If a Participating Pharmacy erroneously bills Part D for a drug for which coverage is available under Part A, Prime will recoup any money incorrectly paid through the Pharmacy audit process and educate the Participating Pharmacy of the error.

For more information, refer to the Medicare Part B vs. Part D Coverage Issues document on [Prime's website](#).

For additional processing requirements, refer to the Payer Specification Sheets on [Prime's website](#).

Additional information on Medicare COB can be found at [http://www.cms.gov/cobpartd/01\\_overview.asp](http://www.cms.gov/cobpartd/01_overview.asp).

## Utilization Management Program

### **Drug Formularies**

Prime manages many Drug Formularies for Benefit Sponsors and administers them through the POS system. The formularies are developed and approved by Prime's National Pharmacy and Therapeutics (P&T) Committee and client-specific P&T or Business Committees, which are independent panels of physicians and pharmacists representing various practice disciplines. P&T and Business Committees meet quarterly to review the current formularies and add or delete drugs.

Per the Pharmacy Participation Agreement with Prime, when providing any Prescription Drug Service to a Covered Person, the Participating Pharmacy shall comply with the pharmacy benefit administered by the Benefit Sponsor for that Covered Person.

## Section 2: Claims Processing (Continued)

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When a non-formulary product is prescribed, and the Covered Person has a closed formulary benefit, the claim will reject with NCPDP rejection code 70 'NDC Not Covered.' The Participating Pharmacy should make an effort to contact the Prescriber to ask if the prescription can be changed to a formulary product.

### Medicare Drug Formularies

Medicare formularies for the following year are published on Prime's website in October; prior to the year they become effective. Formulary supplements are added to the website twice monthly to complement the static formularies. The supplements identify additions, deletions and tier changes to the formularies.

If drugs are removed from the formulary, or prior authorization, quantity limits and/or step therapy restrictions are modified, or a drug is moved to a higher cost-sharing tier, Prime will notify all Covered Persons and Prescribers of the change at least 60 days before the change becomes effective. If the FDA deems a drug to be unsafe or the drug's manufacturer removes the drug from the market, then Prime will remove the drug from the formulary and provide notice to Covered Persons who have received the drug.

Covered Person notification is a combination of direct mailing, and web publication and notification. The Participating Pharmacy formulary notifications are available on Prime's website. To view the comprehensive list of Medicare formularies, visit [Prime's website](#).

### Prior Authorization (PA)

There are four types of prior authorizations used by Prime:

- **One-time override** – Used for a dosage change, vacation, lost, spilled or damaged medication. At the time of the fill, the Participating Pharmacy must document the reason for the override on the hard copy or within an electronic system. Electronic notes are

only considered acceptable documentation when the Participating Pharmacy's system automatically dates and time stamps the entry. The Participating Pharmacy may request prior authorization for a dosage change or vacation request by calling the Prime Contact Center.

- **Formulary exception** – Used for Covered Persons sensitive or unresponsive to the formulary medication requested by the Prescriber. If the Benefit Sponsor has elected to utilize this PA, Prime will provide the Participating Pharmacy POS messaging for additional instructions on requesting a formulary exception. There are three ways to obtain a Request for a Formulary Exception form:
  1. The Prescriber can contact the Benefit Sponsor by phone or in writing based on the information provided on the Covered Person's ID card.
  2. The Covered Person can call the member service toll-free number on the back of the Covered Person's ID card.
  3. The Covered Person can visit their Benefit Sponsor's website.
- **Clinical prior authorization** – Used for medication that requires clinical review specific criteria to be met before the medication is covered by the Benefit Sponsor. If the Benefit Sponsor has delegated this function to Prime, then Prime will review the prior authorization requests to determine if the Covered Person is eligible for coverage. In these cases, Prime requires clinical documentation from the Prescriber. Regardless, the Covered Person should always contact the service department at their Benefit Sponsor if they have any questions. Examples of medications included in the clinical prior authorization program include growth hormone or pegylated interferons. These drugs will reject with the NCPDP reject codes of 75 or 76, 'PA required.' POS messages will vary based on the drug or program and may include quantity limit or step therapy requirements in addition to prior authorization.

## Section 2: Claims Processing (Continued)

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- **Dynamic prior authorization (dPA)** – Some Benefit Sponsors use an automatic override process referred to as dynamic PA. A Participating Pharmacy enters a pre-determined prior authorization number for certain conditions, such as a vacation request or dosage change. At the time of the fill, the Participating Pharmacy must document the reason for the override on the hard copy or within an electronic system. Only electronic notes are considered acceptable documentation when the Participating Pharmacy’s system automatically dates and time stamps the entry. A Participating Pharmacy may request prior authorization for a dosage change or vacation override. For the most current information on medication that requires prior authorization, visit the Covered Person Benefit Sponsor’s website.

### Step Therapy/Contingent Therapy Programs

Some Benefit Sponsors require the Covered Person to try one or more preferred medications before a non-preferred medication is considered for payment. This is referred to as step therapy. Refer to the Benefit Sponsor formulary to determine if a drug is subject to step therapy. Examples of medications that may be included in the step therapy programs include ACE inhibitors/ARBs and statins. For the most current information on step therapy, visit the Covered Person’s Benefit Sponsor’s website.

### Quantity Limit

Many Benefit Sponsors restrict the quantity that may be dispensed on certain drugs, such as proton pump inhibitors or tobacco cessation medications. These limits follow clinical dosing guidelines and restrict the dispensing of the drug to a maximum quantity. When submitting a claim that exceeds the maximum quantity, the claim will receive NCPDP reject code 76 ‘Plan Limits Exceeded.’ A free-form text message accompanies the rejection and indicates the maximum quantity that may be dispensed, assuming the prescription order is for at least that amount. A Participating Pharmacy must electronically accept Prime’s POS messaging.

If the quantity exceeds the Covered Person’s benefit, the Participating Pharmacy must reduce the quantity prescribed and provide refills. If the Covered Person requests a smaller amount, the Participating Pharmacy may reduce the quantity prescribed. The pharmacist should document this on the hard copy at the time of the fill or prior to dispensing on the electronic documentation to reflect the Covered Person’s request. Electronic documentation must have a system assigned user, date and time stamp in order to take the place of hard copy documentation.

### Drug Utilization Review (DUR)

Prime monitors drug utilization to support your role as a professional in providing quality care to all Covered Persons. Prime will alert Participating Pharmacies through the POS system in situations that include, but are not limited to:

- Drug regimen compliance screening
- Drug-drug interaction screening
- Drug-inferred health state screening
- Dosing/duration screening
- Drug-age caution screening
- Drug-sex caution screening
- Duplicate prescription screening
- Duplicate therapy screening

The Participating Pharmacy is responsible for reviewing any claim with a DUR rejection from the POS. The Participating Pharmacy is responsible to ensure that their systems accept DUR messaging. Pharmacists should use professional judgment to follow up with the Covered Person and counsel them regarding the DUR messages.

## Section 2: Claims Processing (Continued)

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While Prime's concurrent DUR edits utilized during the claim submission and adjudication process are important steps toward complying with CMS regulations, they are not the only appropriate measures. As a Participating Pharmacy in Prime's Medicare Programs network, Prime requires Participating Pharmacies to review, update and/or implement quality assurance systems and procedures at the POS to ensure compliance with CMS regulations. Participating Pharmacies are required to obtain the Covered Person's allergy information and refer to it before dispensing. In addition, Participating Pharmacies must ensure that all employees or other agents who dispense medication are aware of and use these drug utilization review systems and procedures and follow currently accepted standards for contemporary pharmacy practice as established by the applicable jurisdiction.

### **Maximum Allowable Cost (MAC)**

Prime's MAC program includes drugs that are reimbursed at an upper limit per unit price. Highly utilized products are reviewed on a regular basis. However, individual products may be adjusted as-needed based on market conditions. If the availability of a drug becomes limited, the MAC will be temporarily suspended or the drug may be permanently removed from the MAC list(s) at Prime's sole discretion. The drug may be added back when Prime's market sources confirm adequate supply and distribution.

If a Participating Pharmacy would like access to Prime's MAC list(s), refer to Prime's website for registration instructions. After your network participation is verified, the Participating Pharmacy will receive a secure user name and password via email to access Prime's MAC list(s).

### Post Claim Adjudication

#### **Return to Stock – Unclaimed Prescriptions**

The Participating Pharmacies are required to reverse any claim that is not delivered to or received by the Covered Person within 14 days of submission, per the terms of the Prime Therapeutics Pharmacy Participation Agreement.

## Section 3: Benefit Plan

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Existing benefits may change without prior notice to the Participating Pharmacy. New Benefit Plans may be added at the request of a Benefit Sponsor. The point-of-sale (POS) system will provide the Participating Pharmacy with current benefit information.

Brief explanations of common benefit designs are listed in the following sections. Keep in mind that these conditions may or may not apply to a particular Benefit Sponsor.

### Product Selection Code (PSC)

For purposes of this Manual, Dispense as Written (DAW) and PSC are used interchangeably. A Participating Pharmacy must submit an accurate PSC, in accordance with NCPDP specifications, when processing claims electronically.

PSC submissions may change the calculation of the claims adjudication, depending upon the Benefit Plan.

### Generic Substitution

Prime encourages its Participating Pharmacies to dispense generics whenever possible. However, there are instances where the Prescriber may request that a brand-name product be dispensed instead of the equivalent generic; these claims must be submitted with a PSC of 1. If a PSC of 1 is used in processing a claim, the written prescription, at the time of the fill, must contain documentation of the DAW order from the Prescriber. If the prescription is telephoned in, the pharmacist must manually write “DAW” on the prescription so it is documented in writing. In addition, Covered Persons may request a brand-name product be dispensed instead of the generic equivalent. A Participating Pharmacy must indicate on the prescription that the Covered Person requested the brand-name product and submit the claim using a PSC of 2.

The Covered Person’s copayment for PSC 1 or 2 may vary based on the Benefit Plan design. Some Benefit Sponsors may require the Covered Person to pay the difference between the brand-name product and the generic equivalent.

### Generic Drug Standards

A Participating Pharmacy must dispense a generic drug whenever permitted and in accordance with applicable laws.

A Participating Pharmacy must stock a variety of generic drugs coinciding with the habits of Prescribers and/or Benefit Sponsor’s formulary as indicated by the claims system response and other correspondence, or the generic formulary of the state in which the Participating Pharmacy is located.

### Enhanced Pharmacy Programs

#### Vaccine Administration for Medicare Programs

Participating Pharmacies that dispense and administer Vaccines must follow all applicable laws, regulations and guidelines governing the sale and administration of Vaccines including ensuring proper personnel compliance and licensing.

“Vaccine” means a specially prepared antigen, which upon administration to a person, will result in immunity, or any other definition that is required by applicable law. “Vaccine Administration Fee” means a fee payable to the Participating Pharmacy for administering a Vaccine by the act of injection in accordance with applicable law.

A Participating Pharmacy must submit its claim for the Vaccine Administration Fee to Prime electronically and must accompany the related ingredient cost submission and dispensing fee. Thus, the ingredient cost, dispensing fee and Vaccine Administration Fee must be submitted to Prime as a single claim.

Visit [Prime’s website](#) for more details regarding the vaccine administration program, including the following:

- [Vaccine Processing Requirements and Administration Fee](#)
- [Complete Software set up](#)

## Section 3: Benefit Plan (Continued)

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### **Medication Therapy Management Program (MTMP)**

Prime is committed to optimizing therapeutic outcomes through improved medication use, as well as through the reduction of adverse drug events. Prime has developed an outpatient pharmacy MTMP that provides MTM enrolled Covered Persons with direct pharmacist intervention for severe drug-drug interactions. Participating Pharmacies must contract with Prime to provide MTMP services in order to receive payment for performing MTMP interventions.

In order to receive reimbursement for MTMP interventions, Participating Pharmacies must submit appropriate Professional Pharmacy Service (PPS) code. See Retail MTMP online fee processing instructions posted on [Prime's website](#).

### Medicare Part D Transition Process

To address the needs of individuals who use certain drug regimens and educate Covered Persons on what drugs are covered by their Part D Benefit Sponsor, CMS requires that Part D Benefit Sponsors establish an appropriate transition process to provide Covered Persons with a temporary supply of prescription drugs in certain circumstances, including, but not limited to, Covered Persons whose current drug therapies are not included in their new Part D Benefit Sponsor's formulary or are subject to certain limits such as a prior authorization or step therapy. The transition process gives Covered Persons time to work with their Prescriber to switch to a therapeutically equivalent medication or to complete a formulary exception request.

When a Covered Person in their transition period (i.e., within 90-days of their eligibility) presents a prescription for a drug that is not on the Part D Benefit Sponsor's formulary and is not excluded from coverage by CMS, the claim will return with a message to the Participating Pharmacy. It explains that the drug will not be covered after the transition period. At retail, Covered Persons will be limited to a one-time 30-day transitional fill of a non-formulary drug. LTC Covered Persons are allowed multiple fills during their 90-day transition period.

For Covered Person's who continue enrollment in the same Part D Benefit Plan whose drugs are no longer on the Benefit Sponsor's formulary, Prime will make a meaningful transition within the first 90-days of the new year. The transition will be made by providing a transition process consistent with the transition process required by new enrollees beginning in the new contract year or making a transition period prior to the beginning of the new contract year.

A primary goal of the transition process is to alert the Covered Person of non-formulary circumstances. Prime will provide instructions to Participating Pharmacies through POS messaging if a Covered Person receives a prescription drug during their transition period that will not be covered post-transition because the drug is not on the formulary, requires a prior authorization or does not meet step therapy requirements. Pharmacists receiving this message must communicate the information on to the Covered Person and suggests that the Covered Person contact their Prescriber to explore transitioning to a formulary drug. Retail Covered Persons will receive a letter from the Benefit Sponsor notifying them how to proceed in transitioning to a formulary drug.

Examples of POS messaging during the transition period include:

- Message for a Covered Person in their transition period impacted by formulary changes:
  - › *"The drug will reject post transition grace period. Alert the member to contact Prescriber. If a new member <or=90 days, call **800.821.4795**."* Refer to Prime's website for current formulary listings.
- In cases where a drug would normally be subject to step therapy or prior authorization edits, a Participating Pharmacy may also receive informational POS messaging such as:
  - › *"This drug subject to step therapy post transition grace period."* Alert member to contact Prescriber.
  - › *"This drug requires a PA post transition grace period."* Alert member to contact Prescriber.

## Section 3: Benefit Plan (Continued)

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- Message for a Covered Person who is continuing enrollment in the same Part D Benefit Plan as shown here:
  - › “*Transition Across Contract Years fill call 800.781.4795 for more information.*” Refer to Prime’s website for current formulary listings.

Participating Pharmacies must ensure that a Covered Person in transition leaves the pharmacy with the appropriate medications. If you have questions regarding the transition process or claims processing, please contact Prime’s Contact Center at 800.821.4795.

### **Medicare Long-Term Care Guidelines and Procedures**

Participating Pharmacies that provide services to Covered Persons in a LTC facility must be familiar with the following guidelines:

- Claims must be billed in 30-day increments no more than once per month.
- Seven-day unit packages must be logged and billed no more than once per month.
- Over-the-Counter (OTC) products must be dispensed in the original container.
- OTC products may not be priced higher than the shelf price.
- Items that are normally supplied by the LTC on a per-diem basis, such as test strips and syringes, are not billable to Prime.
- Unique dispensing methods such as tray changes every two or seven days, do not justify additional fees. One fee per month is reimbursable even when the product is delivered to a LTC facility.
- If providing Prescription Drug Services to Covered Persons residing in a LTC facility, or through mail order services, the Participating Pharmacy shall maintain a delivery log or other evidence specifically approved by Prime at each pharmacy location to acknowledge delivery of Prescription Drug Services to the Covered Person or the Covered Person’s LTC facility, as applicable.

## Section 4: Responsibility of Participating Pharmacy

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### Update Information with NCPDP

National Council for Prescription Drug Programs (NCPDP) requires that Participating Pharmacies submit pharmacy information updates to NCPDP directly as soon as the Participating Pharmacies are aware of them. To submit adds, changes, deletes, current address and phone number to NCPDP, go to NCPDP's website at [www.ncdpdponline.org](http://www.ncdpdponline.org).

Prime receives and incorporates NCPDP's updates, which include changes to a Participating Pharmacy address, phone number and Pharmacy Chain/Pharmacy Service Administration Organization (PSAO) affiliation updates. Prime's system supports only one NCPDP affiliation at this time.

In order to ensure the integrity of Prime's data, it is the Participating Pharmacy's responsibility to contact NCPDP when information changes. This will ensure that correct data is in Prime's database.

### Participating Pharmacy's Affiliation with PSAO

For a copy of Prime Therapeutics Pharmacy Participation Agreement, a Participating Pharmacy should contact their PSAO.

### Responsibilities of the Participating Pharmacy for Medicare Programs

In order to ensure compliance with CMS regulations, Participating Pharmacies in Prime's Medicare Network(s) must adhere to the guidelines outlined on Exhibit C(s) – Prime Medicare Networks that is part of the Prime's Pharmacy Participation Agreement. A copy of Exhibit C & C-1 – Prime Medicare Networks is available on [Prime's website](#).

Participating Pharmacies are required to post in a public area, or hand out with each Covered Person's prescription order, a copy of the 'Medicare Prescription Drug Coverage and Your Rights' document. To print a copy of this CMS-required document please visit [Prime's website](#).

### Additional Participating Pharmacy Information

Prime maintains websites to serve Covered Persons and Participating Pharmacies. Information on the site includes:

- Current formulary information (updated on a regular basis)
- Grievances, coverage determinations, appeal procedures, exception process management and/or drug utilization management
- Participating Pharmacy addresses and types (e.g., retail, mail service pharmacy, home infusion, long-term care)
- Quality control policies and procedures, including Medication Therapy Management Program (MTMP) and/or Drug Utilization Management (DUM)

## Section 5: Participating Pharmacy Audit

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Prime conducts pre-payment daily claims reviews as well as desktop and on-site audits to monitor compliance with state and federal regulations, Prime Therapeutics Pharmacy Participation Agreements and this Manual. Audits verify the integrity of claims submitted to Prime and payments made to the Participating Pharmacy. They also confirm the accuracy of claim information submitted to identify instances of potential fraud, waste and abuse.

Audits comply with federal and state laws to ensure privacy and confidentiality of all patient records. Audits also comply with Health Insurance Portability and Accountability Act (HIPAA) guidelines related to disclosure for treatment, payment or health care operations.

Audit findings may result in payment recoveries, corrective action plans and/or contract terminations. For purposes of the Participating Pharmacy Audit section, recoveries may include excess payments and/or chargebacks.

### Reason for Audits

Several situations could trigger an audit. These situations include, but are not limited to:

- Request or inquiry by a Benefit Sponsor, Covered Person or government agency;
- Pharmacy billing history;
- Pharmacy does not respond to or has significant issues identified through the pre-payment inquiry or pre-payment daily claims review;
- Referral from Prime's Fraud Waste and Abuse Hotline;
- Routine audit of pharmacies selected on a random basis.

### Audit Notification

Participating Pharmacies selected for audit will receive advanced written notice. Advanced notice may not be provided during fraud investigations, as allowed by law.

### Access to Records

Participating Pharmacies must provide adequate access to Participating Pharmacy records related to Prescription Drug Services provided under the Agreement, including but not limited to: invoices, prescription files, licensing and proof of insurance. During an audit, Prime uses these records to compare the submitted claims information to the original source documentation of the prescription orders and other relevant documentation.

If Participating Pharmacies cannot accommodate an on-site audit on the scheduled date and previous arrangements have not been agreed to by Prime, Prime reserves the right to assess a full recovery of any unverified claims. Additionally, if a Participating Pharmacy is uncooperative during an audit, a full recovery of any unverified claims may be assessed.

### Audit Expenses

Participating Pharmacies may not charge Prime for pharmacy personnel time involved in performing an audit. Each Participating Pharmacy is responsible for its own expenses and each Participating Pharmacy shall bear the expense of providing records to Prime.

### Audit Time Frame

Standard on-site audits generally include prescriptions billed to Prime within the previous twenty-four (24) months. Desktop audits generally include prescriptions billed to Prime within the previous twelve (12) months. However, Prime has the right to audit claims for up to seven (7) years from the date of service for commercial claims, and up to ten (10) years from the date of service for government programs claims, or as otherwise permitted by law.

## Section 5: Participating Pharmacy Audit (Continued)

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### Reporting Audit Results

On-site and desktop audit results are provided to the Participating Pharmacy in writing and include details of any issues of non-compliance with federal and state regulations, the Pharmacy Participation Agreement, Prime's Provider Manual and/or discrepancies between the original prescription order documentation available at the time of dispensing and the Participating Pharmacy's claim submission. Prime may place the Participating Pharmacy on a formal corrective action plan (CAP) based on the nature of any discrepancies. Prime may also apply either full or partial recovery of the amount paid for a specific claim. Recovery amounts are included in the audit report.

### Types of Audit Activities

#### **Pre-payment Daily Claims Review**

Prime monitors daily claims data to correct individual quantity and pricing errors on a pre-payment basis. This process educates Participating Pharmacies and helps avoid retroactive audit recoveries that may occur through a pharmacy desktop or on-site audit. The pre-payment daily claims review complements the desktop and on-site audit processes and is not intended to review all audit elements considered in a desk or on-site audit.

If a claim is identified for review, Prime will contact the Participating Pharmacy via telephone, email or fax to inquire about the validity of the claim. If, after the review of the claim and/or prescription hardcopy, a determination is made that there is a billing error, Prime will request that the Participating Pharmacy reverse and correctly resubmit the claim. Prime will contact the Participating Pharmacy only if a resubmission is requested. Other discrepancies noted during the pre-payment daily claims review may be addressed through a desktop or on-site pharmacy audit.

Participating Pharmacies are expected to respond to Prime's requests for information within two (2) business days. Participating Pharmacies must return requested information by the dates provided. Failure to do so may result in full or partial recovery of the amount paid, escalation to a desktop and/or on-site audit or termination of the Pharmacy Participation Agreement.

#### **Desktop Audits**

When a desktop audit is initiated, the Participating Pharmacy is contacted via fax, email or UPS. During a desktop audit, the Participating Pharmacy is asked to provide photocopies of specific prescriptions in question related to claims paid to the Participating Pharmacy during a specified time period. Requested documentation may include, but is not limited to:

- Photocopies of original prescriptions; front and back;
- Signature or delivery logs;
- Computer records;
- Wholesaler, manufacturer, and/or return vendor invoices;
- Compound information including all ingredients with NDCs and quantities;
- Prescription labels; and
- License information.

If the Participating Pharmacy processes LTC Facility claims, the following additional information may also be requested:

- Demographic information of any LTC facilities that were serviced by the Participating Pharmacy during the time frame being audited;
- Medication administration records of the Participating Pharmacy and/or the LTC facility; and
- LTC facility census information for members during the time frame audited that provides information on Part A stays.

## Section 5: Participating Pharmacy Audit (Continued)

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Prime will provide the Participating Pharmacy with a due date for submitting audit documentation. The Participating Pharmacy may either fax, mail or email copies of requested documentation.

Fax Number: **877.765.4551**

E-mail Address: [pharmacyaudit@primetherapeutics.com](mailto:pharmacyaudit@primetherapeutics.com)

Mailing Address:

**Prime Therapeutics LLC**

**Attn: Pharmacy Audit**

**P.O. Box 64812**

**St Paul, Minnesota 55164-0812**

A Participating Pharmacy's failure to submit the requested documentation by the due date may result in full or partial recovery of the amount paid, escalation to an on-site audit or termination of the Pharmacy Participation Agreement. Late fees may apply to missing or late audit documentation.

A Prime auditor will review the requested claims for accuracy to verify that the claims have been submitted in compliance with the Pharmacy Participation Agreement and Prime Provider Manual. Prime will provide the Participating Pharmacy with a written audit report, which will include details of any discrepancies or relevant audit findings.

### **On-site Audits**

Prime may conduct on-site audits of Participating Pharmacies. A written audit notification will be provided to the Participating Pharmacy prior to a scheduled audit date. This notification includes the audit time frame and types of documentation that will be reviewed during the on-site audit.

On-site audits are conducted during regular business hours. Prime makes reasonable efforts to minimize disruption to all areas of the Participating Pharmacy. Participating Pharmacies are expected to provide Prime with access to all areas of the pharmacy and have the documentation to support the audit period readily retrievable and accessible. Participating Pharmacies are also expected to be adequately staffed during the audit and have a representative (either

pharmacist or technician) available to respond to questions and retrieve specific prescription hard copies and supporting documentation that may be needed.

While on site, the auditor will observe the Participating Pharmacy practices and review all related documentation. An interview will be completed, preferably with the Pharmacist in Charge (PIC). Requested documentation may include, but is not limited to:

- Original prescriptions, front and back;
- Signature or delivery logs;
- Computer records;
- Wholesaler, manufacturer and/or return vendor invoices;
- Compound information including all ingredients with NDCs and quantities;
- Insurance information; and
- License information.

On-site audits will involve the disclosure of Covered Persons' personal health information for the purpose of disclosure for treatment, payment or health care operations. In order for both parties to remain HIPAA compliant, a pharmacy staff member will need to retrieve documentation; however the auditor must be present to observe the documentation retrieval. Participating Pharmacies may not refuse to comply with an audit on the grounds that it would violate HIPAA or other relevant privacy laws.

A Prime auditor will review the requested claims for accuracy in order to verify that the claims have been submitted in compliance with the Pharmacy Participation Agreement and this Manual.

Audit documentation, including prescriptions and supporting documentation, will be scanned by the auditor as necessary.

When the audit is complete, the auditor will verbally provide general feedback.

Prime will provide the Participating Pharmacy with a written audit report, which will include details of any discrepancies or relevant audit findings, within approximately thirty (30) days of the on-site visit.

## Section 5: Participating Pharmacy Audit (Continued)

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A Participating Pharmacy's failure to cooperate with an on-site audit may result in full or partial recovery of the amount paid for the related claims reviewed or termination of the Pharmacy Participation Agreement.

### Prescription Requirements

"Prescription Hard Copies" means written prescriptions, refill authorizations, institutional orders, verbal or telephoned orders, facsimile orders, prescription transfers and electronic prescriptions relied on by the Participating Pharmacy at the time of dispensing. In order to qualify as an electronic prescription, the electronic prescription must be noted prior to dispensing and have a system assigned user, date and time stamp in order to take the place of hard copy documentation.

The Participating Pharmacy must retain all documentation related to a prescription claim in accordance with the Pharmacy Participation Agreement and applicable state and federal laws. A prescription is considered valid when the original prescription contains the following information at the time of dispensing:

- Full name, address and date of birth of the Covered Person
- Full name, NPI and telephone number of the Prescriber and, if the prescription is for a controlled substance, the Prescriber's DEA number. If the Prescriber did not include their NPI/DEA number(s) on the prescription hard copy, then the pharmacy is responsible for acquiring the Prescriber ID either from the pharmacy's claim system or by contacting the Prescriber. The Participating Pharmacy must document the correct Prescriber ID on the prescription hard copy or on a prescription label, affixed to the back of the prescription hard copy.
- Name of medication and strength prescribed
- Quantity authorized by the Prescriber
- Specific dosage directions – the medication dispensed to the Covered Person must be labeled with the Prescriber's directions for use. The Participating Pharmacy must

obtain specific directions for use to accurately fill the prescription. Specific directions for use are required, "As Directed" is not allowed. Directions may be obtained through direct communication with the Prescriber or, if the Prescriber is not available, the Covered Person. Directions must be noted on the prescription hard copy and the medication dispensed to the Covered Person must be labeled with the specific directions for use obtained from the prescriber. For drugs that are administered on a sliding scale, such as insulin, the Participating Pharmacy must obtain the dosage range or maximum per day prior to dispensing.

- Substitution instructions with appropriate documentation – when medically necessary, the Prescriber may write "Dispense as Written" on the prescription, or in the case of a telephoned prescription, the pharmacist must manually write "Dispense as Written" on the written prescription order. If the Covered Person requests a brand-name drug, the Participating Pharmacy must document the request on the prescription hard copy.
- Refill instructions – if there are no refills indicated by the Prescriber, the Participating Pharmacy should assume that there are no refills. If refills are added to a prescription, the Participating Pharmacy must retain written documentation of the authorization and assign a new prescription number.
- Prescription number – the prescription hard copy must be labeled with the corresponding prescription number.
- If the prescription is for a drug under a federally regulated program (for example, iPledge or S.T.E.P.S. Data 2000), the Participating Pharmacy must document the authorization number obtained from the program on the prescription hard copy before dispensing.
- Documentation of the date the prescription was received and the name of the caller for verbal or telephoned prescription orders or clarification to any order.

Prescription hard copies that are missing one or more of the required elements may be considered invalid and subject to audit recovery.

## Section 5: Participating Pharmacy Audit (Continued)

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### Prescription Label Requirements

The prescription label must contain the following elements in addition to state and federal guidelines:

- Full name of Covered Person
- Full name of Prescriber
- Full name and strength of medication dispensed
- Quantity of medication dispensed
- Specific directions for use
- Prescription number
- Number of refills authorized
- Date of dispensing

### Billing Requirements

Prime auditors will, at a minimum, verify the following claim elements when evaluating a prescription:

- **Covered Person** – The prescription must contain the full name of the Covered Person and be billed under the correct Covered Person ID number.
- **Date of Issuance** – The date of issuance must be present on the prescription.
- **Drug name and strength** – The NDC on the claim must correspond with the specific drug and strength prescribed. Reasonable efforts must be made to select the most cost effective form of the prescribed drugs or its generic equivalent.
- **Price** – The accuracy of calculating and submitting compound prices.
- **Product selection codes (PSC)** – PSC submissions will be verified. If the Participating Pharmacy submits a DAW-1 and no written substitution directive is present on the prescription, the claim(s) will be subject to a chargeback. When the Covered Person requests the brand-name, the Participating Pharmacy must document the Covered Person's request on the original hard copy and submit the claim with a DAW-2.
- **Quantity** – The Participating Pharmacy must dispense the quantity as written, unless the quantity written exceeds the Covered Person's benefit. The Participating Pharmacy must comply with POS messaging, such as messaging regarding the Covered Person's benefit limit and document the reason for dispensing a lesser quantity on the original prescription. In order to prompt accurate POS messaging, the Participating Pharmacy must accurately represent the day supply.
- **Days supply** – The Participating Pharmacy must submit the correct days supply, based upon directions for use. The Participating Pharmacy must submit the number of consecutive days the prescription drug will last. Overstating the days supply may affect future refills, while understating the days supply may exceed the Covered Person's benefit. The most common days supply errors occur when dispensing inhalers, insulin and medication with intermittent dosing. Unit of uses packages days supplies are calculated based on the number of doses available. A Participating Pharmacy is responsible for submitting the correct days supply. For examples of medications commonly billed erroneously, visit [Prime's website](#).
- **Refill instructions** – Refill history will be reviewed to assure that the prescription was not refilled in excess of the prescription order. If additional refills are authorized, the Participating Pharmacy must obtain written documentation and assign a new prescription number.
- **Claims edits** – If the Participating Pharmacy receives specific messaging when a claim is submitted, the Participating Pharmacy must ensure that documentation is maintained to support the use of dynamic prior authorization (override or DUR override) numbers. Inappropriate use or lack of supporting documentation related to dynamic prior authorizations will be subject to audit recovery.
- **Prescriber ID number** – The Participating Pharmacy must enter the correct Prescriber's ID number on the claim submission. Claims submitted under the wrong Prescriber ID number will be subject to audit recovery.

## Section 5: Participating Pharmacy Audit (Continued)

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- **Usual and Customary Charge (U & C)** – The lowest price the Participating Pharmacy would charge to a particular customer if such customer were paying cash for the identical Prescription Drug Services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts and other special discounts offered to attract customers.

Discrepancies between the claim submission and original prescription are subject to audit recovery.

### Distributor and Manufacturer Invoices

To substantiate that the drugs dispensed were purchased from an authorized source, Prime may request that the Participating Pharmacy authorize the wholesaler or manufacturer to release invoices for purchase verification. The Participating Pharmacy must promptly comply with such requests. If the Participating Pharmacy fails to provide authorization, Prime has the right to assess a full recovery of the amount paid for any claims in question.

### Common Billing Errors

- **Quantity dispensed** – Overstating the days supply may affect future refills, while understating the days supply may exceed the Covered Person’s benefit, while assessing less copayments that are applicable. The Participating Pharmacy must submit the correct days supply, based on directions for use and benefit limitations to avoid an audit recovery. For example, incorrectly calculating the day supply of eye drops. Calculate eye drops day supply using 15 drops per mL for solutions and 12 drops per mL for suspensions.
- **Reversal of claims** – All prescriptions not received by the Covered Person within fourteen (14) days must be reversed through the electronic claims system.

- **Use as directed** – The Participating Pharmacy must determine the specific dosing directions to accurately calculate the days supply and correctly submit the claim to Prime. The Participating Pharmacy must contact the Prescriber to clarify any ambiguous directions (i.e. “Use as Directed,” no directions documented or “As Needed”) and document them on the prescription hard copy. If the Prescriber is unavailable, communication with the Covered Person is acceptable and must be documented. If specific dosing directions are not obtained, the accuracy of the amount paid to the Participating Pharmacy cannot be substantiated and is subject to audit recovery.

- **One prescription for entire family** – Prescriptions written for an entire family on one prescription form must be processed as separate claims for each Covered Person.

For examples of medications commonly billed erroneously, visit [Prime’s website](#).

### Unacceptable Practices

Based on the claims submission requirements, the following are examples of unacceptable and, in some cases, fraudulent practices:

- Billing for a legend or OTC drug without a prescription or benefit-sponsored voucher
- Submitting incorrect information on claims which may lead to the inappropriate bypass of benefit exclusions, DUR messages, or other Benefit Plan edits
- Billing for a quantity of a legend drug which is greater than the quantity prescribed
- Billing for a higher priced drug when a lower priced drug was prescribed and/or dispensed to the Covered Person
- Dispensing a generic drug but billing for the brand-name drug
- Submitting a claim with an NDC other than the NDC from the package from which the product was dispensed

## Section 5: Participating Pharmacy Audit (Continued)

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- Dispensing a smaller quantity than was prescribed, which results in the collection of more than one professional dispensing fee (prescription splitting) (If a Covered Person requests a smaller amount, a notation must be made on the hard copy of the prescription prior to dispensing.)
- Billing more than once per month for maintenance drugs for Covered Persons in a LTC facility (A maintenance drug is a drug ordered on a regular, on-going, scheduled basis. This limitation does not apply to treatment medications or drugs ordered with a stop date of less than 30 days.)
- Overriding DUR rejects without properly resolving and documenting the resolution
- Incorrectly billing Part A or Part B eligible drugs to a Part D program
- Billing compound products in a manner inconsistent with the compound billing requirements described in the Compound Billing Guidelines of this Manual
- Misrepresenting U & C
- Billing the Covered Person for any associated chargebacks
- Misrepresenting the origin codes

### Audit Appeal Process

Participating Pharmacies have thirty (30) days from the date of notification of audit findings to submit an appeal or an extended time frame as required by law or regulation. Appeals must be submitted in writing and include the Participating Pharmacy's name, the claims/prescriptions in question and an explanation of the appeal. Prime will not accept documentation that is required to be available at the time of dispensing but was obtained post-audit. Documentation accepted during the appeals process may provide information that results in additional audit findings. For a copy of Prime's Pharmacy Audit Appeal Form, visit [Prime's website](#).

### Corrective Action Plan (CAP)

Participating Pharmacies placed on corrective action plans are monitored to determine whether the identified issues have been remedied. If issues are not resolved, additional action may be taken by Prime, as permitted by the Agreement. Failure to comply with the terms of the corrective action plan may result in termination of the Pharmacy Participation Agreement.

### Termination Appeals

Pharmacy termination appeals must be submitted in writing to the Pharmacy Network Contracting Department by fax at **877.823.6373** or by email to: [pharmacyops@primetherapeutics.com](mailto:pharmacyops@primetherapeutics.com)

A Participating Pharmacy that has been terminated from Prime's pharmacy networks may reapply one year after the effective date of their termination.

### Confidentiality and Proprietary Rights

#### Confidentiality

Any information (including, but not limited to, products, programs, services, business practices, procedures, MAC lists or other information acquired from the contents of the Pharmacy Participation Agreement, Provider Manual or other Prime documents) or data obtained from, or provided by, Prime or any Benefit Sponsor to the Participating Pharmacy is highly confidential. The Participating Pharmacy shall not sell, assign, transfer or give such information to any third party without the prior written consent of Prime.

## Section 5: Participating Pharmacy Audit (Continued)

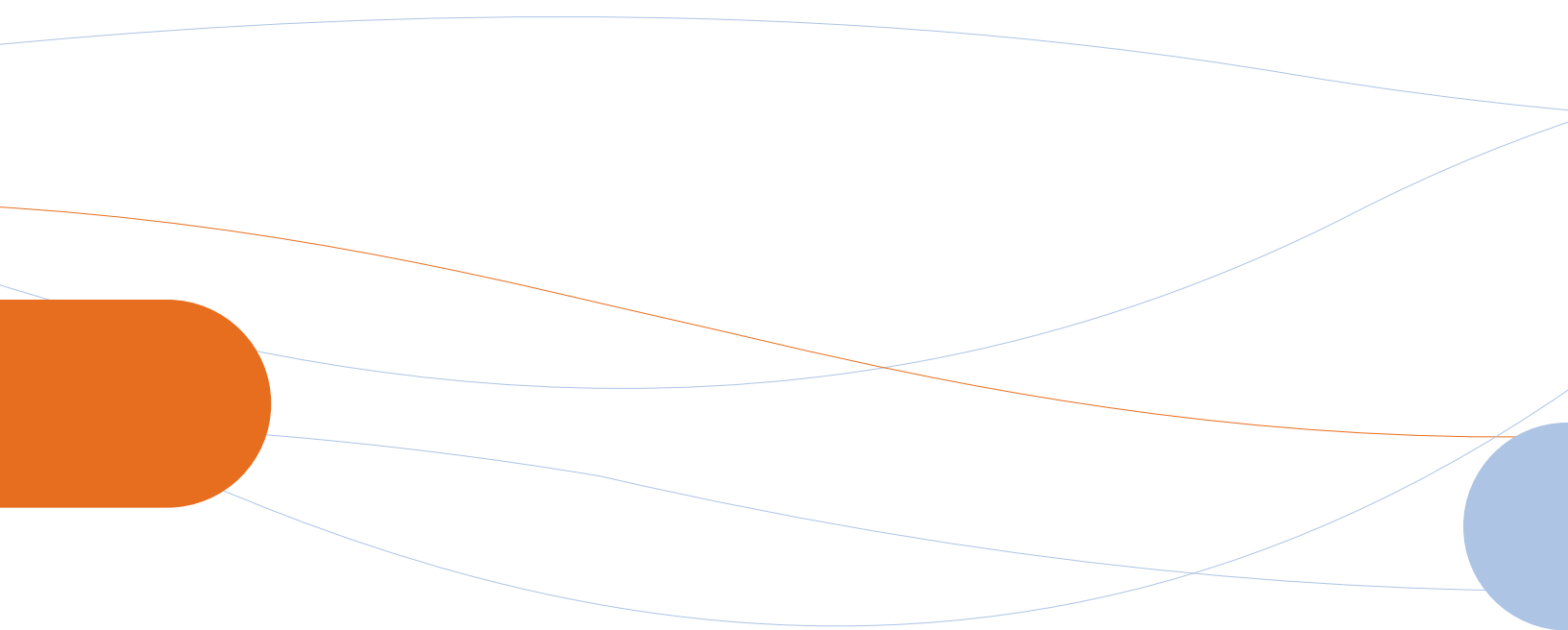
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- No information or data obtained from or provided by Prime to the Participating Pharmacy may be quoted or attributed to the Participating Pharmacy or Prime without the prior written consent of Prime.
- Prime and the Participating Pharmacy must use all necessary security procedures to ensure that all information and data exchanges are authorized and to protect any information or data records from improper access.
- The Participating Pharmacy must maintain the confidentiality of a Covered Person's personal profile and records as required by applicable law. The Participating Pharmacy may not use the information provided by Covered Persons for any purpose not related to the Agreement, except to the extent such use is required by applicable law.
- The Participating Pharmacy must promptly notify Prime if it becomes aware of any unauthorized use of confidential information or data.

### **Proprietary Rights**

Except as required to fulfill the Participating Pharmacy's obligations under the Agreement, the Participating Pharmacy has no right to use, reproduce or adapt any information, data, work, compilation, computer programs, manual process or invention obtained from, provided by, or owned by Prime and/or Benefit Sponsor (including, but not limited to, products, programs, services, business practices and procedures) without Prime's prior written consent.

Prime has the right to use, reproduce and/or adapt any information or data obtained from the Participating Pharmacy in any manner deemed appropriate, even if such use is outside the scope of the Pharmacy Participation Agreement, provided such use is in accordance with applicable law.



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