

Prime Therapeutics
Provider Manual



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Introduction to Prime Therapeutics LLC

Prime Therapeutics LLC (Prime) is a pharmacy benefit management (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 Covered Persons.

Prime manages pharmacy networks to provide Prescription Drug Services for its clients through Prime's online claims processing system. The claims processing system gives Participating Pharmacies real-time access to member 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 requires 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. This version of the Provider Manual supersedes all previous versions of the Manual. Prime posts the most current version of the Provider Manual on its website at [PrimeTherapeutics.com](https://www.PrimeTherapeutics.com).

Relevant instructions, notices, information and supplements or changes to the Manual are posted on the [Prime website](https://www.PrimeTherapeutics.com). Consult [PrimeTherapeutics.com](https://www.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 all lines of business, including, but not limited to Medicare, Medicaid, and commercial business.

Section 1: Prime Contact Information

Prime Mailing Address

If you would like additional information, contact Prime at:

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

Prime Contact Center

800.821.4795

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

Prime's Website

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

- Current formulary and negative 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 (MTM) and/or Drug Utilization Management

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

- [Payer Specification Sheets](#)
- [Medicare Plan-Specific Reference Guides](#)
- [Medicare Coverage and Rights](#)
- [Formulary Information/Formulary Updates](#)
- [Prime Perspective Newsletters](#)
- [Fraud, Waste and Abuse Training, Requirements and Certification Materials](#)
- [FWA Referral Form](#)
- [Plan Announcements](#)
- [Network Request Form General Information and Services](#)
- [Common Billing Errors](#)
- [Minimum Performance and Service Criteria for Medicare Programs](#)
- [Minimum Performance and Service Criteria for Medicare Programs LTC](#)
- [Medicare Part B vs. Part D Coverage Issues](#)
- [Pharmacy Audit Appeal Form](#)
- [Pharmacy Audit Guidelines](#)
- [Prime Audit Advisor Fax Series](#)
- [Long Term Care and Home Infusion Processing Requirements](#)
- [National Provider Number \(NPI\)](#)
- [Medicaid Programs](#)
- [Vaccine Administration Processing Requirements](#)
- [Check Inquiry Form](#)
- [Maximum Allowable Cost \(MAC\)](#)

Section 2: Compliance

Compliance

If you have a compliance concern or suspect or have knowledge of fraud, waste or abuse, please report the issue using the email or telephone numbers below.

Anonymous Compliance Hotline

800.474.8651

- An independent operator is available 24 hours per day, 7 days a week

Compliance@primetherapeutics.com

Anonymous Online Reporting

- Reports@lighthouse-services.com
- www.lighthouse-services.com/Prime

Fraud Waste and Abuse Hotline

800.731.3269

Use this number to report suspected fraud, waste or abuse. You will be asked to leave a voice mail. You do not need to leave your name or contact information.

ReportFraud@primetherapeutics.com

Compliance Question Line

612.777.5523

Prime Therapeutics
Chief Compliance Officer
P.O. Box 64812
St. Paul, MN 55164-0812

Privacy Hotline

888.849.7840

Privacy@primetherapeutics.com

Participating Pharmacies must develop policies and procedures in compliance with all applicable rules and regulations, including but not limited to, Medicare Programs. All Participating Pharmacies should have someone who is responsible for establishing a plan to meet Medicare Programs requirements and appropriate documentation of that plan. The Participating Pharmacies should communicate the plan and any means of enforcing the plan to all employees.

Refer to the CMS website, [CMS.gov](https://www.cms.gov), for a complete list of compliance program requirements.

Please contact Prime's Compliance Department with any concerns, including concerns regarding:

- Violation of a state, federal, local law, regulation or any governmental guidance
- Conflict of interest
- Acceptance and/or offers of gifts or entertainment
- Fraud, waste or abuse
- Improper disclosure of Prime's confidential or proprietary information
- Retaliation for reporting a compliance issue
- Falsification of reports, records or files
- Theft

Section 2: Compliance (Continued)

Fraud, Waste and Abuse (FWA)

Both Participating Pharmacies and Prime have an obligation to help protect and maintain the integrity of the health care system by promptly reporting suspicious activity.

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.

Please contact Prime's Fraud, Waste and Abuse Department (see Compliance section) with any concerns, including:

- **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 the Prescriber's patients. These scripts are usually written, but not always, for drugs found on a schedule of controlled substances 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 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)
 - › Billing an NDC not used to dispense the prescription
 - › Billing an NDC or drug that was never ordered
 - › Billing an incorrect dosage form. (i.e., billing for tablet when powder is used to dispense the prescription)
 - › Prescription splitting to receive additional dispensing fees
 - › Drug diversion

Section 2: Compliance (Continued)

- **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 higher number of refills than what was prescribed by the Prescriber.
- **Illegal remuneration schemes (kickbacks)** — A pharmacy is offered, solicits, or receives unlawful remuneration which results in inducement or reward for switching Covered Persons to different drugs, influencing Prescribers to prescribe different drugs, or steering 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 available to the member through his or her benefit plan.
- **Annual Attestation Requirement** — Pharmacies participating in Prime's Networks must attest on an annual basis to the completion of Fraud, Waste and Abuse training required by state and federal programs including the Centers for Medicare and Medicaid Services (CMS). For your convenience, training and the Certification of Compliance form are available on [Prime's website](#). Failure to attest to the annual FWA training may result in termination from Prime's networks.

Section 3: Claims Processing

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. UCFs are available on the NCPDP website at [NCPDPOnline.org](https://www.ncdpd.org).

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

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

In order for Prime to assist Participating Pharmacies with claims adjudication, email your unique processing codes CONDOR CODES/INPUT CODES to PharmacyOps@primetherapeutics.com.

Medicare Reference Materials

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

- [Fraud, Waste and Abuse Training](#)
- [MA-PD Contact Reference Guide](#)
- [Medicare Prescription Drug Coverage and Your Rights](#)
- [Medicare Processing Guide](#)
- [PDP Contact Reference Guide](#)

Eligibility

Member Identification 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, the Participating Pharmacy must 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, a Covered Person whose eligibility has been verified should never:

1. Be denied a Prescription Drug Service (subject to a 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.

Schedule II prescriptions for members residing in a long-term care facility or terminally ill members may be partially filled, not to exceed the quantity prescribed and must be dispensed within 60 days from the issue date.

Except in emergency situations or when dispensed directly by a Prescriber, Schedule II drugs may not be dispensed without a Prescriber's written prescription.

Schedule II prescription drugs may not be refilled, unless members are residing in a long-term care facility or are terminally ill. In both cases where a Schedule II drug can be refilled, the total quantity dispensed cannot exceed the total quantity prescribed.

Section 3: Claims Processing (Continued)

In accordance with 45 CFR § 155.430, Prime may direct Pharmacy to reverse claims for Prescription Drug Services and any other related actions. If Pharmacy is unwilling or unable to reverse requested claims, Prime will reverse claims on behalf of Pharmacy by providing written notice to Pharmacy.

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 real-time transaction submitted by the Pharmacy to the RelayHealth Medicare Part D Transaction Facilitator, to help determine a Covered Person's Part D coverage and payer order if they have multiple insurance coverage. Pharmacies generally submit E1 Queries when a Covered Person does not have their Part D ID card.

Additional information on E1 Transactions can be found at <http://medifacd.relayhealth.com/e1>

Best Available Evidence (BAE)

Covered Persons who are eligible for Low Income Subsidy (LIS) under the Medicare Part D prescription drug program 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 (POS). 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 **800.445.7085**.
- 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 Covered Person 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 Covered Person'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.

Hospice Best Available Evidence (BAE)

Covered Persons who are in hospice will have medications for the terminal illness and related conditions paid by their hospice providers. Some medications submitted under Medicare Part D will reject at point of sale (POS) for Covered Persons in hospice care. In the event the claims system does not show the correct hospice status for the Covered Person, the Participating Pharmacy is required by CMS to accept BAE when presented at the POS. CMS also requires Participating Pharmacies to assist Covered Persons who should not be covered under hospice, but do not have BAE documentation.

Section 3: Claims Processing (Continued)

If the Covered Person was never in hospice:

- The Participating Pharmacy must contact Prime's Contact Center and request a hospice Prior Authorization (PA). The PA form will then be faxed to the Covered Person, the Covered Person's physician, or to the Participating Pharmacy to give to the Covered Person.

If the Covered Person was in hospice, but has since been released:

- The Participating Pharmacy must fax the Covered Person's letter of revocation indicating the date the revocation is to be effective, the hospice provided Notice of Medicare Non-Coverage (NOMNC), or the hospice provided discharge indicating the Covered Person has left hospice, to Prime's Clinical Review at 800.693.6703.

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.
- **Prescriber Identifiers** — Prime will accept the Prescriber's DEA, State Licenses or Individual NPI (preferred). Pharmacy must have processes in place to ensure they are submitting the correct Prescriber Identifier at POS. Claims submitted without a valid DEA, State License or Individual NPI number will reject at POS (some rejected claims may allow for a Submission Clarification Code [SCC] Override Code). As of the CMS compliance date, Pharmacy must submit the Prescriber's NPI for all Medicare Part D claims. Claims will be monitored on a daily basis to ensure they are submitted with the correct Prescriber Identifier.

Prime will contact the Pharmacy to correct any claims identified as submitted with an invalid Prescriber Identifier to update their system for future claims. Failure to resubmit the claim or update your system for future claims with the correct identifier may result in termination from Prime's networks.

Medicare Enrollment

As of the CMS compliance date, CMS requires Prime to reject a pharmacy claim for a Part D drug if the physician or eligible professional is not enrolled in the Medicare program in an approved status, and does not have a valid opt-out affidavit on file with a Part A and Part B Medicare Administrative Contractor (A/B MAC). Reject Codes include: 773 'Medicare Fee For Service has terminated' or 774 'Prescriber not listed within Medicare Fee For Service active enrollment file'.

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. Pharmacy should not request changes to a prescription for the sole purpose of avoiding POS messaging. For example, if pharmacy receives a POS message that a prior authorization is required or that pharmacy must call the Prime Contact Center, pharmacy is expected to follow the POS messaging and Prime Contact Center instructions. Pharmacy should not request the Prescriber to change the prescription in any way to avoid POS messaging. 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 for non-Medicare Part D Claims

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, if the days' supply is inaccurately submitted.

Section 3: Claims Processing (Continued)

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

Example: Covered Person's benefit allows up to a 30-day supply. One inhaler will last 40 days. The Participating Pharmacy must bill the inhaler as a 30-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 up to a 30-day supply. One inhaler will last 28 days. The Covered Person receives one inhaler as a 28-day supply. Varies by Benefit Plan.

Days' Supply for Medicare Part D Claims

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, if the days' supply is inaccurately submitted. There are some prescription products that cannot be broken in which the calculated day supply may exceed common values (e.g. greater than 30 days or greater than 90 days). In these instances the pharmacy should submit the accurately calculated day supply.

Example: Lupon Depot 30 mg for a 120-day administration should be submitted with a 120-day supply.

For a small subset of prescription products that cannot be broken where the smallest unit exceeds the maximum benefit days' supply and where there is subjectivity in calculating a day supply (e.g., topical products), the Participating Pharmacy must submit the maximum days' supply allowed under the benefit.

Example: Covered Person's benefit allows up to a 30-day supply. One unbreakable unit may last 40 days, depending upon the amount used, but a course of therapy should be limited to 28 days (e.g., clobetasol shampoo). The Participating Pharmacy must bill the bottle as a 30-day supply.

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

Example: Covered Person's benefit allows up to a 30-day supply. One inhaler will last 28 days. The Covered Person receives one inhaler as a 28-day supply. Varies by Benefit Plan.

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, unless otherwise required by law.

Medicare E-prescribing

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.

Section 3: Claims Processing (Continued)

Prescription Origin Code

The Participating Pharmacy must submit all claims with the corresponding prescription origin code: 1-Written, 2-Telephone, 3-Electronic, 4-Facsimile.

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.

Requirements for Participating Pharmacies Contracted with 340B Covered Entities

The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible pharmacies at significantly reduced prices. 42 USC 256b(a)(5)(A)(i) prohibits duplicate discounts; that is, manufacturers are prohibited from providing drugs at a discounted 340B price and receiving a Medicaid drug rebate for the same drug. Participating Pharmacy must have mechanisms in place to prevent duplicate discounts.

To view the specific claim processing requirements for Prime's Medicaid programs, please go to [PrimeTherapeutics.com/Pharmacists](https://www.primetherapeutics.com/pharmacists) and click on Medicaid 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 a zero (0) in the NDC portion of the claim using the Compound segment.
- Enter the qualifier, NDC, quantity, cost and cost basis for each ingredient in the compound.
- Submit the Final Product Quantity. The Final Product Quantity is the quantity of the finished compound product.
 - › For a liquid, submit the number of mL of the finished compound product.
 - › For capsules, submit the total number of capsules being dispensed.
 - › For creams or ointments, submit the total number of grams being dispensed.
- Submit the Total Ingredient Cost. For Total Ingredient Cost, 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) for each eligible ingredient used. Then, add all of the individual ingredient costs to submit as the Total Ingredient Cost.
 - › 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. NDCs submitted for the compound must be the exact formulation of what is dispensed in the compound.
- Prime will accept a multiple ingredient compound submission utilizing NCPDP's Compound Segment for up to 25 ingredients.
- Dynamic prior authorizations for processing compounds which contain situational Medicare Part B versus Medicare Part D drugs will not apply, even if the compound meets the criteria for inclusion as a Medicare Part D covered drug. A one-time prior authorization will be issued if the claim meets the criteria for coverage under Medicare Part D.
- Prime will support submission clarification codes for most of Prime's business. The Participating Pharmacy must submit the submission clarification code of "08" for all compounds to allow payment of all covered ingredients.
- Compounds containing a Medicare Part B ingredient must be processed under Medicare Part B.

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

Section 3: Claims Processing (Continued)

Prime administers pharmacy benefits on behalf of many different plan sponsors. Each individual plan sponsor determines benefit plan design, such as the specific drugs/ingredients covered, cost-sharing and day supply limitations, among other benefit design attributes.

The following are examples of compound drugs where benefit designs may vary:

- Modified-release compounds (based on member benefit design).
- 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.
- For Medicare business, compound components, methods of administration, or other criteria that do not satisfy the definition of a Medicare drug.
- Experimental/investigational items, products or services.
- Any finished product intended to address medical diagnosis (such as sugar-free products) where the Covered Person's medical diagnosis does not support the need for the finished product.
- Any compound that differs from the equivalent commercial form only by the addition of cosmetic agents or agents intended to produce a cosmetic effect.

Prime does not consider the following a compound drug and these drugs cannot be submitted to Prime 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 except in some limited situations in which the compound is preferred according to the Benefit Plan. This exception may vary by state.

Prime considers the following additional unacceptable billing practices for compound drugs:

- Billing for a different NDC than what was used in the compound.
- Billing for the full package size when only a partial amount was dispensed to the patient.
- Billing for a different dosage form than what was used in the compound.
- Billing for a quantity other than what was actually used to prepare the compound.
- Any compound to which active ingredients are added that were not part of the prescription order.
- Not following POS messaging, including but not limited to messaging for rejected claims.
- Billing claims in a manner that bypasses system messaging requiring further review. For example, billing claims multiple times in a month to avoid obtaining a prior authorization or reaching plan dollar thresholds.
- Obtaining changes to prescription orders to avoid POS messaging.

If you have questions regarding compound drugs, please contact Prime's Contact Center at **800.821.4795**.

General Insulin and Diabetic Supply 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 a sliding scale is used, the Participating Pharmacy must obtain and document maximum and minimum quantities at the time of dispensing. Directions limited to "Use as Directed" are not accepted.

Section 3: Claims Processing (Continued)

Insulin Supplies

- Unless indicated by the POS system, insulin syringes and needles are generally a covered benefit.
- A valid prescription is required for insulin supplies 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.
- Diabetic supplies submitted to insurance are considered prescriptions, and must follow all terms and conditions outlined in the Manual.

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

Prime requires LTC and HIT Participating Pharmacies to submit NCPDP D.0 fields as outlined on the Payer Sheets. Processing guidelines for submitting LTC and HIT claims are located on [Prime's website](#).

Medicare Programs Coordination of Benefits (COB)

COB claims for Medicare Programs should be processed in 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 generally accommodates multiple supplemental plans and includes information required to process the supplemental claim(s).

Supplemental claims must be processed through a switch in order to correctly capture these transactions for accurate TrOOP calculations. 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 Relay Health to determine proper payer order. Prime's Supplemental to Medicare Payer Specification Sheet is available on [Prime's website](#).

Additional information on Medicare COB can be found at [CMS.gov/COBPartD](https://www.cms.gov/COBPartD).

Time Limits for Coordination of Benefits

The time limits for coordinating benefits with State Pharmaceutical Assistance Programs (SPAPs), 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, such as drugs covered under the hospice or End Stage Renal Disease (ESRD) benefits. 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. For example, Participating Pharmacies may receive a NCPDP Reject Code of 569 which requires the Participating Pharmacy to distribute the Prescription Drug Coverage and Your Rights form, which informs Covered Persons of their right to request and receive a coverage determination. 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.

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.

Section 3: Claims Processing (Continued)

Notwithstanding the Participating Pharmacy's obligation to reverse ineligible claims, Prime may, at its discretion, reverse ineligible Part D claims. For example, Prime conducts outreach to Participating Pharmacies to reverse previously adjudicated claims that have been identified with a retroactive ESRD date of service. The Participating Pharmacies must reverse the claim and resubmit to the Covered Person's Medicare Part B coverage. If the Participating Pharmacies fail to reverse the claim as directed, Prime will reverse the claim.

If a Participating Pharmacy erroneously bills Part D for a drug where coverage is available under Part A or Part B, Prime will recoup any money incorrectly paid through the pharmacy audit process and educate the Participating Pharmacy of the error. Retroactive recoupment for hospice drugs may be coordinated directly with the hospice and/or Covered Person.

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](#).

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.

Pursuant to Prime's Pharmacy Participation Agreement, 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.

When a non-formulary product is prescribed, and the Covered Person has a closed formulary benefit, the claim will reject with NCPDP rejection code MR Non Formulary. 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 beginning in October; prior to the year they become effective. Medicare formularies are updated on a monthly basis to reflect additions, deletions, tier changes and utilization management changes. Updated publications are posted on [Prime's website](#) on a monthly basis.

During the benefit year, if drugs are removed from the formulary, or prior authorization, quantity limits and/or step therapy restrictions are modified to be more restrictive, or a drug is moved to a higher cost-sharing tier, Prime will notify utilizing Covered Persons and Prescribers of the change as well as post a negative change notification to [Prime's website](#), 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, web publication and notification. The Prescribers and 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 six 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

Section 3: Claims Processing (Continued)

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 are growth hormones or pegylated interferons or compounds. These drugs will reject with the NCPDP reject codes of 75, 'PA required' or 76 'Plan Limitations Exceeded.' POS messages will vary based on the drug or program and may include quantity limit, step therapy or clinical necessity requirements in addition to prior authorization. For the most current information on medication that requires prior authorization, visit the Covered Person's Benefit Sponsor's website.
- **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, adverse weather, 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. Electronic notes are only 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.
- **Appropriate payor verification** — This authorization is used specifically for certain drugs (e.g. Cialis and fentanyl) in Medicare Part D that have the highest likelihood of non-Part D covered uses. Claims for these drugs should reject at the point-of-sale and require a prior authorization to determine that (1) the Covered Person's use of that drug is eligible for coverage under Medicare Part D and (2) the Covered Person's use of that drug satisfies any of the Benefit Sponsor's CMS-approved utilization management criteria. NOTE: Medicare Part D Transition — If a Covered Person is within their transition period, the Covered Person will not immediately receive a temporary supply of these drugs as they do other drugs that are covered under Medicare Part D. Following Prime's review of a prior authorization request for one of these drugs, Prime may determine that the Covered Person's use of that drug is covered under Part D but is not covered under the Benefit Sponsor's CMS-approved utilization management criteria. In these cases, Prime may conduct outreach to the pharmacy where the initial claim rejected and inform that pharmacy that the Covered Person is eligible to receive a temporary supply of these drugs during the remainder of their transition period.

Section 3: Claims Processing (Continued)

- **Hospice prior authorization** — CMS has determined that the following categories of drugs to be generally payable under Medicare Part A when prescribed to Covered Persons that have elected hospice: laxatives, antiemetics, antianxiety agents, and analgesics (nonnarcotic, opioid, and anti-inflammatory). Claims will reject with the NCPDP reject codes of A3-Product May Be Covered Under Hospice — Medicare A, and 75 — Prior Authorization Required. The Participating Pharmacy should generally work with the Hospice Care provider for payment for drugs within the four categories listed above. However, if the Hospice Care provider (or non-hospice prescriber) determines that a drug within one of these four categories is unrelated to the Covered Person's terminal illness or related condition, the drug would be eligible for coverage under Medicare Part D. In this case, a Hospice Prior Authorization is required. The drug may still need to satisfy any other existing Utilization Management criteria in order to be payable under Medicare Part D. Covered Persons, a Covered Person's authorized representative, or a Covered Person's primary care provider can follow the standard coverage determination process to request a Hospice Prior Authorization. Additionally, the Hospice Care Provider can submit a Hospice Prior Authorization Form on the Covered Person's behalf to request the Hospice Prior Authorization.
 - › In certain situations where the Covered Person's eligibility incorrectly indicates that they are actively enrolled in Hospice and their claim for a drug in these four categories rejects at the pharmacy due to this incorrect eligibility, a Hospice Prior Authorization may be required in order to override the incorrect eligibility and allow the Covered Person's claim to adjudicate. As mentioned above, the Covered Person, the Covered Person's authorized representative or the Covered Person's primary care provider can submit a coverage determination or the Hospice Care Provider can submit the Hospice Prior Authorization Form in order to request the Hospice Prior Authorization.

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 ARBs/renin inhibitors and proton pump inhibitors. For the most current information on step therapy, visit the Covered Person's Benefit Sponsor's website. These drugs will reject with the NCPDP reject codes of 75 'PA required' or 608 'Step Therapy Alternate Drug Therapy Required Prior to Use of Submitted Product Service ID' and 76 'Plan Limitations Exceeded.' POS messages will vary based on the drug or program and may include quantity limit, step therapy, or clinical necessity requirements in addition to prior authorization.

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.

Section 3: Claims Processing (Continued)

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
- Additive toxicity screening

The Participating Pharmacy is responsible for reviewing any claim with a DUR alert from the POS system.

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.

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. All products are reviewed on a regular basis and will 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), weekly MAC changes, MAC pricing appeals process, and the sources used to determine MAC pricing, please refer to [Prime's website](#) for registration instructions. After 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

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 4: Benefit Plan

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 prescription order, 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 document or have a computer time and date stamp 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

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 processing instructions, including software set up for the vaccine administration program.

Section 4: Benefit Plan (Continued)

Medication Therapy Management (MTM)

Prime is committed to optimizing therapeutic outcomes through improved medication use and the reduction of adverse drug events. Prime does this through both an internal MTM department and external MTM vendors that provide annual Comprehensive Medication Review (CMR) services for MTM-enrolled Covered Persons. Prime also provides quarterly, criteria-based Targeted Medication Review (TMR) services to MTM-enrolled Covered Persons.

Prime enrolls members into the MTM program who meet specific criteria. Eligible members can complete a CMR by contacting our call center at 1.866.686.2223.

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, CMS requires that Part D Benefit Sponsors support an appropriate transition process to provide Covered Persons with a temporary supply of prescription drugs in certain circumstances, including, but not limited to, current drug therapies not included in their new Part D Benefit Sponsor's formulary or subject to certain limits such as a prior authorization (PA), step therapy (ST), or quantity limits (QL). The transition process gives Covered Persons time to work with their Prescriber to switch to a therapeutically equivalent medication or to obtain a formulary exception or prior authorization.

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 paid transition claim will return a message to the Participating Pharmacy that explains the day supply of the drug covered is limited during the transition period.

If the claim is submitted for a day supply greater than what is allowed during the transition period, or if the Covered Person had already obtained a transition supply and the claim is rejected, the reject message to the Participating Pharmacy explains the reason, as noted in the messaging examples provided on the next page.

At retail, Covered Persons will be limited to a 30-day transitional fill of a non-formulary drug or a drug subject to PA, ST and/or QL. If a previous retail claim was submitted for 15-day supply, they are still eligible for another 15-day supply of that drug while in their transition period. The exceptions to the 30-day supply limit are drugs packaged in such a way they cannot be dispensed for fewer days than recommended (for example, Lupron Depot Inj. 11.25 mg which is prepackaged in a 3-month supply). LTC Covered Persons are allowed up to a 31-day supply per fill to a maximum of 98-days supply with multiple fills, during their transition period unless that drug is packaged in such a way it cannot be dispensed for fewer days (as in the Lupron example above). The 98-day supply maximum takes into consideration those drugs that require Short Cycle Dispensing. (Refer to section, "Medicare Short Cycle Dispensing Long-Term Care Guidelines and Procedures").

Pharmacies, including Extended Supply Network (ESN) and Mail Order, must remember that they may get a reject message indicating that a Covered Person may not obtain more than the day supply limits noted above—however, please refer to all messaging. A claim may require other corrections or override codes. This should be done prior to reducing the day supply to accommodate the transition day supply limit as the claim may allow benefits without doing so. If the claim remains rejected after all other corrections or overrides have been completed and the transition message is advising of the day supply limit, at that time the day supply should be reduced.

Section 4: Benefit Plan (Continued)

Since a Covered Person may have received a partial fill during their transition period, it is important to check their history for the drug by NDC9 to see if you are able to provide them the remainder of their transition supply. For instance, in the retail setting they may have received a 9 day transition supply. They are still eligible for the remaining 21 days under their transition benefit during their transition period.

Important Notice—To meet CMS requirements, Covered Persons in transition must not leave the Pharmacy without their medications as a result of the day supply being submitted for a greater amount than what is allowed. For Covered Persons who continue enrollment in the same Part D Benefit Plan and whose recently utilized drugs (within 365-day look-back period) are no longer on the Benefit Sponsor’s formulary and/or to which a utilization management limitation has been added, 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 for new enrollees beginning each new year or making a transition prior to the beginning of the new contract year.

A primary goal of the transition process is to alert the Covered Person of the non-formulary status of their drug and/or if their drug is subject to PA, ST, and/or QL. Prime will provide instructions to Participating Pharmacies through POS messaging if a Covered Person receives a prescription drug during their transition period that the drug will not be covered post-transition because the drug is not on the formulary or subject to utilization management programs. Pharmacists receiving this message must communicate the information to the Covered Person and suggest that the Covered Person contact their Prescriber to explore transitioning to a formulary drug or request a formulary exception or prior authorization. Covered Persons will receive a letter from the Benefit Sponsor notifying them how to proceed in transitioning to a formulary drug or request a formulary exception or prior authorization.

Reasons for and examples of RETAIL POS messaging during the transition period:

- If the claim is rejecting because the day supply being submitted is greater than the allowed day supply for that drug during the transition period:
 - › “MAX OF 30DS DURING TRANSITION PERIOD. RESUBMIT W/LESSER DS. AUTH OR FORM ALT REQ. CALL 800.821.4795 IF NEW/RE-ENROLLEE.”
- If the claim is rejecting because the Covered Person has already received a full or partial transition supply (based on the NDC 9) during their transition period:
 - › “AUTH OR FORM ALT REQ/NONFORM/UM MEDS. MAX 30 DAY SUPPLY IN TRANSITION PERIOD. <##> DAY SUPPLY REMAINS CALL 800.821.4795.”
- When there is a paid claim the NCPDP code “004” will be returned indicating:
 - › “FILLED IN TRANSITION BNFT.”

Reasons for and examples of LTC POS messaging during the transition period:

- If the claim is rejecting because the day supply being submitted is greater than the allowed day supply for that drug during the transition period:
 - › “MAX OF 31 DS/FILL IN TRANSITION PERIOD. RESUBMIT W/LESSER DS. AUTH OR FORM ALT REQ. CALL 800.821.4795 IF NEW/RE-ENROLLEE.”
- If the claim is rejecting because the Covered Person has already received a full or partial transition supply (based on the NDC 9) during their transition period:
 - › “AUTH OR FORM ALT REQ/NONFORM/UM MEDS. MAX 98 DAY SUPPLY IN TRANSITION PERIOD. <##> DAY SUPPLY REMAINS CALL 800.821.4795.”
- When there is a paid claim the NCPDP code “004” will be returned indicating:
 - › “FILLED IN TRANSITION BNFT.”

Refer to [Prime’s website](#) for current formulary listings.

Section 4: Benefit Plan (Continued)

Covered Persons in transition must leave 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 General Dispensing Long-Term Care Guidelines and Procedures

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

- Claims must be billed in 30-day increments no more than once per month unless the claim meets the short cycle requirements.
- 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 facility 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 dispensing fees. One dispensing fee per month is reimbursable even when the product is delivered to an LTC facility.
- If providing Prescription Drug Services to Covered Persons residing in an LTC facility, or through mail order services, the Participating Pharmacy shall maintain a delivery log—which includes the prescription number, date of fill, delivery date and signature of Covered Person(s) receiving medication—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. Receipts and other documentation showing the co-pay (if applicable) was paid by the Covered Person or their representative.
- For the most up to date guidelines and procedures for Long-Term Care, please visit [Prime's website](#).

Medicare Short Cycle Dispensing Long-Term Care Guidelines and Procedures

Participating Pharmacies servicing LTC facilities must dispense solid oral doses of brand-name drugs to Medicare Covered Persons residing in LTC facilities in no greater than 14-day increments at a time in accordance with 42 CFR §423.154. Prime will reject LTC facility claims that are submitted with invalid or missing SCC combinations.

The following fields must be submitted on all LTC short cycle claims:

- NCPDP Field 147-U7 Pharmacy Service Type
- NCPDP Field 307-C7 Place of Service
- NCPDP Field 384-4X Patient Residence
- NCPDP Field 997-G2 CMS Part D Defined Qualified Facility

Please visit [Prime's website](#) for detailed processing requirements.

Section 5: Responsibility of Participating Pharmacy

Update Information with NCPDP

The 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, fax number and phone number to NCPDP, go to NCPDP's website at [NCPDPOnline.org](https://www.ncpdp.org).

Prime receives and incorporates NCPDP's updates, which include changes to a Participating Pharmacy address, fax number, 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.

OIG/GSA Exclusion Checks

CMS requires that all individuals and businesses that contract to provide Medicare services must make sure that everyone they employ is eligible to receive federal funds.

A Participating Pharmacy has an obligation to make sure it does not employ, or contract with, any individual or business that is excluded or debarred from participation in Medicare or state healthcare programs. As required, exclusion checks must be conducted prior to contracting or hiring and monthly thereafter. Please see the following sources for more information:

- [Office of the Inspector General \(OIG\) website](#)
- [General Services Administration \(GSA\) website](#)
- [System for Awards Management \(SAM\) website](#)
- [CMS Prescription Drug Benefit Manual, Chapter 9](#)

Participating Pharmacy's Affiliation with PSAO

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

Participating Pharmacies must notify NCPDP immediately upon change of affiliations with a PSAO. Failure to do so can result in a violation of the Health Insurance Portability and Accountability Act (HIPAA).

Third Party Payment Reconciliation Vendors

Participating Pharmacies must notify Prime immediately upon change of Payment Reconciliation Vendors. Failure to do so can result in a violation of HIPAA.

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 which is part of Prime's Pharmacy Participation Agreement. A copy of minimum performance and service criteria for Prime's Medicare Networks is available on [Prime's website](#).

CMS requires retail and mail pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery. This is an effort to control fraud, waste, and abuse as required by 42 CFR § 423.504, and to ensure that Medicare Covered Persons only receive new prescriptions and refills as requested. CMS and Part D Plan Sponsors received many consumer complaints of unneeded prescriptions being sent as part of auto-ship refill programs.

Section 5: Responsibility of Participating Pharmacy (Continued)

This does not apply to retail Participating Pharmacies that have refill reminder programs that require the Covered Person to pick up the prescription or LTC pharmacies.

Participating Pharmacies are required (when instructed through POS messaging) to hand out with the 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 (in English or Spanish) please visit [Prime's website](#).

Participating Pharmacy shall comply with CMS' Medicare Marketing Guidelines, when applicable. If Prime or Benefit Sponsor identifies a communication not in compliance with CMS' Medicare Marketing Guidelines, Participating Pharmacy shall cooperate with the removal or revision of the communication.

Pharmacy Credentialing

Prime credentials pharmacies prior to entry into Prime's Pharmacy Network. A new pharmacy must complete a credentialing exhibit and supply all of the supporting documents so that Prime can review and process the application.

Prime recredentials all Participating Pharmacies at least once every three years in accordance with applicable law and contractual obligations. Recredentialing is a requirement for continued participation in Prime's Pharmacy Networks. Failure to complete the recredentialing exhibit will be cause for termination.

All participating pharmacies must provide Prime with copies of the following documents on an annual basis:

1. Pharmacy License
2. Pharmacist In Charge License
3. DEA Certificate
4. Certificate of Insurance with proof of General and Professional Liability Insurance

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**

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

Prime reserves the right to terminate Participating Pharmacy from Prime's networks for up to five years, depending on the reason for termination, unless otherwise directed by Prime.

Section 5: Responsibility of Participating Pharmacy (Continued)

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.

- 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.
- The Participating Pharmacy must use all necessary security procedures to ensure protection of any information or data records from improper access.
- The Participating Pharmacy must maintain the confidentiality of a Covered Person's personal profile and records including Protected Health Information (PHI) as required by applicable law, including state privacy laws and the Health Insurance Portability and Accountability Act of 1996 as amended. 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 and must establish privacy and security safeguards as appropriate and necessary.
- 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 disclose, 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.

Section 6: Participating Pharmacy Audit

Auditing is a critical component of responsible pharmacy benefit management. Prime manages a robust program to detect inaccurate payments, drug waste and fraudulent claims or other benefit coverage abuses. As part of this program, Prime regularly samples and audits claims submitted by pharmacies in our networks.

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, claim adjustment, corrective action plans and/or contract terminations. For purposes of the Participating Pharmacy Audit section, please see the Pharmacy Audit Recovery Guidelines for specific criteria on [Prime's website](#).

Education

Prime may provide information to network pharmacies via a monthly Prime Audit Advisor Fax Blast and quarterly via the Prime Perspective. These documents may serve as a tool for pharmacies to use to strengthen documentation and billing practices, prepare for Prime audits and reduce common billing errors.

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 or other sources that indicate potential fraud, waste or abuse
- Routine audit of pharmacies selected on a random basis

Audit Notification

Participating Pharmacies selected for audit may receive advance written notice. Advance notice may not be provided at Prime's discretion or 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: wholesaler invoices, prescription orders, signature log/delivery log, 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.

Section 6 : Participating Pharmacy Audit (Continued)

Participating Pharmacies shall not photograph or record (either audio or video) interactions with Prime auditors, including telephone discussions, on-site audits, or other interactions without Prime's written consent. Such activity may result in termination of the Pharmacy Participation Agreement.

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.

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. A Participating Pharmacy may be immediately terminated from network participation upon Prime's receipt of any evidence of a pharmacy participating in activities that may result in fraud, waste or abuse.

Types of Audit Activities

Pre-payment Daily Claims Review

Prime monitors daily claims data to identify 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 order, a determination is made that there is a billing error, Prime will request that the Participating Pharmacy reverse and correctly resubmit the claim. 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.

Section 6: Participating Pharmacy Audit (Continued)

Desktop Audits

When a desktop audit is initiated, the Participating Pharmacy is contacted via fax, email, United States Postal Service 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
- Receipts and other documentation showing the co-pay (if applicable) paid by the Covered Person or their representative
- Computer records
- Wholesaler, manufacturer, and/or return vendor invoices
- Pedigree invoices
- Compound information including all ingredients with NDCs and quantities
- Prescription labels
- Pharmacy Liability Insurance and Pharmacist-in-Charge Professional Insurance information
- Proof of Fraud, Waste and Abuse training
- License information
- Bill of Sale
- Attestation of compliance with specific state and/or federal statutes, regulation, or CMS guidance

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.

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**

Email Address:

PharmacyAudit@primetherapeutics.com

Mailing Address:

Prime Therapeutics LLC

Attn: Pharmacy Audit

P.O. Box 64812, St. Paul, MN 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

Participating Pharmacies selected for audit may receive advance written notice. Advance notice may not be provided at Prime's discretion or during fraud investigations, as allowed by law.

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 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.

Section 6: Participating Pharmacy Audit (Continued)

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
- Prescription Label
- Signature or delivery logs
- Receipts and other documentation showing the co-pay (if applicable) paid by the Covered Person or their representative
- Tracking number from delivery log must link to the prescription that was delivered
- Computer records
- Wholesaler, manufacturer and/or return vendor invoices
- Pedigree invoices
- Compound information including all ingredients with NDCs and quantities
- Pharmacy Liability Insurance and Pharmacist-in-Charge Professional Insurance information
- License information
- Proof of Fraud, Waste and Abuse training
- Bill of Sale
- Attestation of compliance with specific state or federal statutes, regulation, or CMS guidance

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 or copies will be requested 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.

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 and/or termination of the Pharmacy Participation Agreement.

Drug and Supply Requirements

Participating Pharmacies must purchase all medications and supplies being dispensed to Covered Persons from verifiable licensed wholesalers. The ordering of these medications and supplies must be tracked using verifiable wholesale invoices and pedigree invoices (when required by applicable law). Prime reserves the right to not accept documentation from any wholesalers at any time when the invoice documentation cannot be verified.

Section 6: Participating Pharmacy Audit (Continued)

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. Prescriptions or claims that do not comply with state and federal regulations may be subjected to audit recovery. 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.
- Date of Issuance.
- 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 documented 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 at the time of dispensing. For drugs that are administered on a sliding scale, such as insulin, the Participating Pharmacy must obtain and document 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 order.
- **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 6: Participating Pharmacy Audit (Continued)

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 medication was dispensed

Review of Claim Submission

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 and dispensed. Reasonable efforts must be made to select the most cost effective form of the prescribed drugs or its generic equivalent.
- **NDC** —The NDC on the claim must correspond to the NDC used to dispense the prescription.
- **Price** —The accuracy of calculating and submitting compound prices, based on the NDCs and quantities used to dispense product.
- **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 recovery. 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. If the generic is not available to the market, the Participating Pharmacy must document on the original hard copy and submit the claim with a DAW-8.
- **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 days' 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 the appropriate prescription order based on the drug class.

Section 6: Participating Pharmacy Audit (Continued)

- **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 or an invalid Prescriber ID number may result in the pharmacy being placed on a corrective action plan.
- **Usual and Customary Charge (U&C)** — The Participating Pharmacy will submit 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 order may result in an audit recovery or a formal corrective action plan.

Distributor and Manufacturer Invoices and Pharmacy Dispensing Records

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 and/or Pedigrees for purchase verification. The Participating Pharmacy must promptly comply with such requests. Prime has the right to assess a full recovery of the amount paid for any claims in question. Wholesaler invoices received from wholesaler must be verifiable and shall include Pedigree documentation upon request.

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 days’ supply of eye drops. Calculate eye drops days’ 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.
- **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](#).

Section 6: Participating Pharmacy Audit (Continued)

Unacceptable Practices

Based on the claims submission requirements, the following are examples of unacceptable and, in some cases, fraudulent practices which may be subject to audit recovery:

- 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 different 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.
- For general LTC dispensing, billing more than once per month for legend drugs for Covered Persons in an LTC facility where short-cycle dispensing is not allowed.
- Dispensing drugs that are solid oral dose brand-name drugs in greater than 14-day increments for Short Cycle dispensing.
- 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 recovery.
- Misrepresenting the origin codes.
- Billing for drugs that were never purchased by the pharmacy.

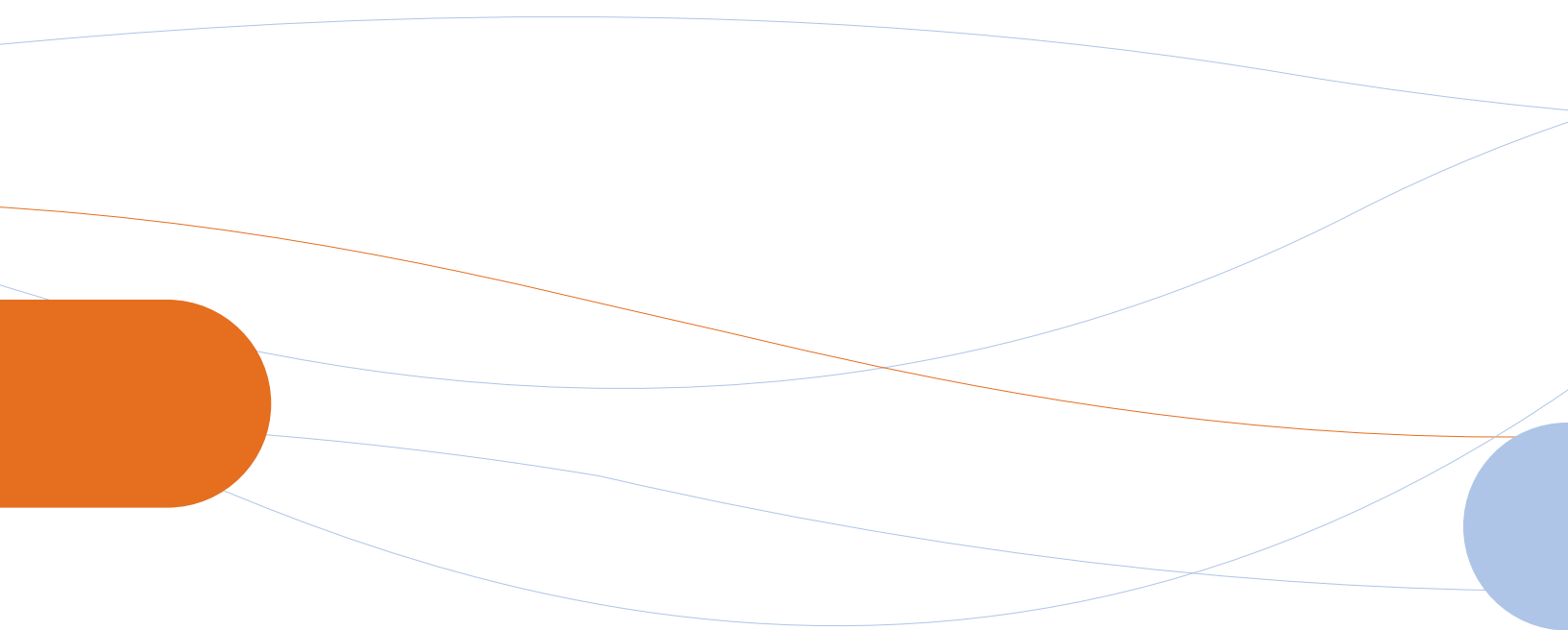
- Billing for drugs where the wholesaler invoices cannot be substantiated by the wholesaler.
- Submitting a claim for a non-FDA approved drug (i.e., compound kits).

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. Please see the Pharmacy Audit Recovery Guidelines for accepted post-audit documentation. 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.



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