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Introduction to Prime Therapeutics

Introduction

Prime Therapeutics LLC (Prime) manages pharmacy benefits for health plans, employers and government programs including Medicare and Medicaid. The company processes claims and delivers medicine to Covered Persons, offering clinical services for people with complex medical conditions.

Prime's services include:
• Pharmacy Network management
• Drug Formulary management
• Pharmacy communication
• Drug utilization review (DUR)
• Clinical programs
• Physician education
• Claims processing

Prime manages Pharmacy Networks to provide Prescription Drug Services for our Benefit Sponsors through our online claims processing system. This system gives Participating Pharmacies real-time access to:
• Covered Person eligibility
• Drug coverage information
• Drugs requiring prior authorization (PA)
• 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. This includes policies and procedures to avoid potential conflicts of interest and Fraud, Waste or Abuse (FWA). Prime requires all Participating Pharmacies to adopt appropriate compliance programs:
• Codes of conduct
• FWA programs
• 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"). Prime will update this Manual as necessary at its sole discretion. This version of the Manual supersedes all previous versions of the Manual. Prime posts the most current version of the Manual at PrimeTherapeutics.com.

Prime posts relevant instructions, notices, information and supplements or changes to this Manual on the Prime Website. Visit 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:

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

Prime’s Contact Center

800.821.4795

Prime’s Contact Center has dedicated staff to assist you. They can help you with contract requests, processing questions, and any comments and concerns you may have. Prime’s representatives are available 24 hours a day, 365 days a year.

Prime’s Website

Visit PrimeTherapeutics.com/pharmacists for the following information:

• Payer specification sheets
• Medicare Plan-specific reference guides
• Medicare coverage and rights
• Drug Formulary information and updates
• Prime Perspective Newsletters
• Fraud, waste and abuse: training, requirements, certification materials and referral form
• Plan announcements
• Network request form: general information and services
• Common billing errors
• Minimum performance and service criteria for Medicare Programs and Medicare Programs LTC
• Medicare Part B vs. Part D coverage issues
• Pharmacy audit appeal form and guidelines
• Prime audit advisor fax series
• Long-Term Care and Home Infusion processing requirements
• National Provider Number (NPI)
• Medicaid Programs
• Commercial Vaccine Administration Network
• Check inquiry form
• Maximum allowable cost (MAC)
Section 2: Compliance

Compliance

If you have a compliance concern, or if you suspect or have knowledge of FWA, please report the issue using the contact information below.

Anonymous Compliance Hotline
800.474.8651
• An independent operator is available 24 hours a 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 FWA. You will be asked to leave a voicemail. You do not need to leave your name or contact information. You can also send an email to: ReportFraud@primetherapeutics.com

Compliance Question Line
612.777.5523

or

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

Privacy Hotline
888.849.7840

or

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 Program requirements and appropriate documentation of that plan. Participating Pharmacies should communicate the plan and any means of enforcing the plan to all employees.

Refer to the Centers for Medicare & Medicaid Services (CMS) website, 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
• FWA
• 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)

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, if the Participating Pharmacy receives a prescription order that appears potentially altered or forged, contact the Prescriber to validate the prescription. At all times, remain mindful of fraud, waste and abuse, and report suspicious activity as soon as possible.

Please contact Prime’s FWA 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.
- **Script mills** – A Prescriber writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for Covered Persons who are not the Prescriber’s patients. These scripts are usually written for drugs found on a schedule of controlled substances for illegal sale. These may also include improper payments to the Prescriber.
- **Theft of Prescriber’s Drug Enforcement Administration (DEA) number or prescription pad** – These are stolen from Prescribers and used to write prescriptions, often for controlled substances or 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-name 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 (POS), 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** – A pharmacy dispenses 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 an incentive 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 the Covered Person is 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 Covered Person through the Benefit Plan.

• **Annual Attestation Requirement** – Pharmacies participating in Prime’s Networks must attest on an annual basis to the completion of FWA training required by state and federal programs including 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. This includes situations where no Pharmacy 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 version.
• The Universal Claim Form (UCF) must be submitted for paper claim submissions. UCFs are available on the NCPDP website at NCPDPOnline.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

Covered Person Identification Card
The Participating Pharmacy shall require a Covered Person to produce a Covered Person identification (ID) card prior to providing a Prescription Drug Service.

The Covered Person Identification Card does not ensure a Covered Person’s eligibility. If a Covered Person does not have a Covered Person Identification Card and the Participating Pharmacy is unsure of eligibility, the Participating Pharmacy must contact Prime’s Contact Center at 800.821.4795 to obtain accurate Covered Person 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 Prime’s Contact Center. Unless expressly allowed in this Manual, a Covered Person whose eligibility has been verified should never:
• Be denied a Prescription Drug Service (subject to a pharmacist’s professional judgment).
• Be asked to pay more than is due under the terms of the Agreement.
• Be asked to pay cash and submit a paper claim.
• If a Covered Person’s eligibility is obtained using an eligibility lookup system, this information must be confirmed with the Covered Person prior to dispensing the product.

In accordance with 45 CFR § 155.430, Prime may direct the Participating Pharmacy to reverse claims for Prescription Drug Services and any other related actions. If the Participating Pharmacy is unwilling or unable to reverse requested claims, Prime will reverse claims on behalf of the Participating Pharmacy by providing written notice to the Participating Pharmacy.
Section 3: Claims Processing

Schedule II Prescription Dispensing Considerations

Schedule II prescription drugs may not be refilled, unless Covered Persons 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.

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

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

Claims Process for Multiples

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

• Process the first claim as usual.
• Attempt to process the second claim as usual.
• If the second claim rejects, contact Prime’s Contact Center at 800.821.4795 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 RelayHealth, the Transaction Facilitator. It helps determine a Covered Person’s Medicare Part D coverage and payer order if they have insurance through more than one provider.

Pharmacies generally submit E1 Queries when Covered Persons do not have their Medicare Part D Identification 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 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 Prime’s Contact Center at 800.445.7085.
• Prime will forward the BAE documentation to the Medicare 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 Medicare 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 an immediate need.
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 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.

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 to Prime’s Clinical Review at 800.693.6703, indicating one of the following:
  - 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.

Submitting the Claim

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

A BIN is required when adjudicating claims through the POS system. A list of the BINs and PCNs used to adjudicate claims through Prime’s POS system can be found on Prime’s Website.

National Provider Identifier (NPI)

- Pharmacy NPI – Participating Pharmacy must have a Pharmacy NPI, and all online claims must be submitted with the Pharmacy NPI. Online claims submitted with the Pharmacy NCPDP number will reject. Reject code “619” is displayed with message “PrescrTyp1NPI Required.”
- Prescriber Identifiers – Prime will only accept a valid, active, individual (Type 01) NPI. The Participating Pharmacy must have processes in place to ensure it is submitting the correct Prescriber Identifier at POS. Claims submitted without a valid NPI will reject at POS. Pharmacy may, through the use of a Submission Clarification Code (SCC), attest that the NPI supplied at POS is or will soon be a valid NPI. The Participating 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 Participating Pharmacy to correct any claims submitted with an invalid Prescriber Identifier and update its system for future claims. Failure to resubmit the claim or update Participating Pharmacy’s system for future claims with the correct identifier may result in termination from Prime’s Networks.
Section 3: Claims Processing (Continued)

Medicare Enrollment

As of the CMS compliance date, CMS requires Prime to reject a Participating Pharmacy claim for a Medicare Part D drug if the physician or eligible Pharmacy Professional:

- Is not enrolled in the Medicare program
- Is not in an approved status
- Is not one of the following Other Authorized Prescribers:
  - Prescribers other than physicians and eligible professionals who are permitted by state or other applicable law to prescribe medications.
  - To prevent unintended interruptions in coverage and potential harm to beneficiaries, Pharmacy claims and beneficiary requests for reimbursement for Medicare Part D prescriptions written by Other Authorized Prescribers shall not be rejected at the POS if all other requirements are met.
- Does not have a valid opt-out affidavit on file with a Medicare Part A and Part B Medicare Administrative Contractor (A/B MAC).

Reject Codes include:

- 773 'Prescriber Is Not Listed On Medicare Enrollment File'
- 774 'Prescriber Medicare Enrollment Period Is Outside Of Claim Date Of Service'
- 829 'Pharmacy Must Notify beneficiary: Claim not covered due to failure to meet Medicare Part D active, valid prescriber NPI requirements'

Provisional Supply:

- When the prescription is written by a Prescriber who is eligible to enroll but who is not enrolled in or opted out of Medicare Part D, Prime will first allow a provisional supply of three (3) months (as prescribed by the Prescriber and that would otherwise be covered by the plan).
- The three (3) month provisional fill is intended to give the Prescriber time to enroll or the beneficiary time to find a new Prescriber.

Documentation

Verbal changes and clarifications to the Prescriber’s prescription order must be documented on the original hard copy or electronically noted in the Participating Pharmacy’s online system prior to dispensing. The Participating Pharmacy should not request changes to a prescription for the sole purpose of avoiding POS messaging. For example, if a Participating Pharmacy receives a POS message indicating a PA is required or that it must call Prime’s Contact Center, the Participating Pharmacy is expected to follow the POS messaging and Prime’s Contact Center instructions. The Participating Pharmacy will not request the Prescriber change the prescription in any way to avoid POS messaging. Electronic documentation must be noted prior to dispensing and must 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.

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. This varies by Benefit Plan.
Section 3: Claims Processing (Continued)

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 days’ 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 days’ supply.

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

A small subset of prescription products cannot be broken. For this subset, the smallest unit exceeds the maximum benefit days’ supply and there is subjectivity in calculating a day’s supply (e.g., topical products). For these, 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: The benefit allows up to a 30-day supply. One inhaler lasts 28 days. The Covered Person receives one inhaler as a 28-day supply. This will vary by Benefit Plan.

Accurate Quantity

The quantity dispensed must be entered exactly as written. Submit metric quantity (including decimal points). Enter the exact metric decimal quantity on claims. Do not round 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 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 Prescription Drug 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.

Prescription Origin Code

The Participating Pharmacy must submit all claims with the corresponding prescription origin code:

- Written
- Telephone
- Electronic
- 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.
Section 3: Claims Processing (Continued)

**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 USC256b(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. The Participating Pharmacy must have mechanisms in place to prevent duplicate discounts. Aside from the Participating Pharmacy’s obligation to follow the claims processing requirements for 340B claims, Prime may, at its discretion, reverse ineligible claims or erroneously billed claims. Prime will recoup any money incorrectly paid through the Pharmacy audit process. The Participating Pharmacy will be notified of the error.

To view the specific claim processing requirements for Prime’s Medicaid Programs, please go to [PrimeTherapeutics.com/Pharmacists](http://PrimeTherapeutics.com/Pharmacists) and then click on Medicaid Programs and/or Payer Sheets.

**Compound Drugs Billing Guidelines**

Participating Pharmacies must submit compound drugs through the 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 used to prepare the compound, quantity, cost and cost basis for each ingredient in the compound.
- The NDC used to prepare the compound must be the NDC that has the lowest cost AWP.
- Submit the final product quantity (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.)
  - 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 using NCPDP’s compound segment for up to 25 ingredients.
- Dynamic prior authorizations (PAs) for processing compounds that 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 PA will be issued if the claim meets the criteria for coverage under Medicare Part D.
- The Participating Pharmacy must follow POS messaging to determine if the ingredients submitted require a prior authorization (PA) prior to submitting the “08” clarification code. If a PA is required, the Participating Pharmacy must follow the POS messaging to obtain a PA. If a PA is not required for one or more ingredients, the Participating Pharmacy may submit the clarification code “08” to allow Pharmacy Payment of all covered ingredients.
- Each benefit set-up determines claim coverage and may vary by Covered Person. As the claim is processed, the Participating Pharmacy receives system messaging on the status of the submission. Participating Pharmacies are required to follow all system messaging.
- 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 or the FDA, and/or may result in termination of your Pharmacy Participation Agreement.

Prime administers pharmacy benefits on behalf of many different Benefit Sponsors. Each individual Benefit Sponsor determines Benefit Plan design, such as the specific drugs/ingredients covered, cost-sharing, days’ supply limitations, and other benefit design attributes.

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

- Modified-release compounds (based on Covered Person 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.

The following drugs cannot be submitted to Prime as a compound drug:

- Reconstituted non sterile products, to which only water, alcohol or sodium chloride solution are added to the active ingredient (for example, children's antibiotic suspensions).
- Any prescription that is subdivided 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.
- Obtaining changes to prescription orders to avoid POS messaging.
- Billing claims in a manner that bypasses system messaging requiring further review. Example: billing claims multiple times in a month to avoid obtaining a PA or reaching plan dollar thresholds.
- Billing claims for a new order prior to verifying the Prescriber/Covered Persons’ relationship.
Section 3: Claims Processing  (Continued)

• Billing compound claims for a Covered Person:
  › Where there is not literature that supports the clinical use,
  › Where the Participating Pharmacy is not registered as a 503B entity with the FDA,
  › From a central fill pharmacy that is not contracted with Prime,
  › In a manner that violates any federal, state or local law regarding compounding, marketing, and/or dispensing compound medications,
  › That resulted in the Participating Pharmacy giving or receiving payment to or from any Prescriber for referrals.

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.

Insulin Supplies
• Unless indicated at the POS, 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 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 (HI) Processing Requirements
Prime requires LTC and HI Participating Pharmacies to submit NCPDP D.0 fields as outlined on the Payer Sheets. Processing guidelines for submitting LTC and HI 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 supplemental plans and includes information 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.

Time Limits for Coordination of Benefits
There are time limits for coordinating benefits with State Pharmaceutical Assistance Programs, other entities providing Prescription Drug Service or other payers. The time cannot exceed three years from the date 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 administered via pump covered under the hospice or End Stage Renal Disease (ESRD) benefits. Participating Pharmacies are responsible for ensuring that claims eligible for coverage under Medicare Part A or Part B are not adjudicated under Medicare Part D. For example, insulin, when used in a pump, should be billed under Medicare Part B.

Participating Pharmacies that serve LTC facilities are required to determine potential Medicare Part A eligibility by reviewing Medicare Part A eligibility information with their contracted LTC facilities.

Participating Pharmacies should seek payment from the LTC facility for Prescription Drug Services for Covered Persons under a qualifying and covered Medicare 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, indicating ‘Provide Notice: Medicare Prescription Drug Coverage and Your Rights,’ requiring the Participating Pharmacy to distribute the Prescription Drug Coverage and Your Rights form. This form informs Covered Persons of their right to request and receive a coverage determination. The Participating Pharmacy must take appropriate steps, as necessary, to ensure Medicare Part A and Part B eligible claim(s) are not adjudicated under Medicare Part D.

In the event the insulin is being used in a pump, the Participating Pharmacy must reverse the claim and submit to Medicare Part B. On applicable insulin products, a POS message will be returned on every claim that states ‘If used in non-disposable pump, submit to Medicare Part B.’ The Participating Pharmacy must ensure the insulin is not being used in a pump to allow the claim to remain paid under Medicare Part D.

A Participating Pharmacy must promptly reverse the Medicare Part D claim(s) after determining that it was eligible for coverage under Medicare Part A or Part B, and refund any Medicare Part D cost-sharing collected from the Covered Person.

Aside from the Participating Pharmacy’s obligation to reverse ineligible claims, Prime may, at its discretion, reverse ineligible Medicare Part D claims. Prime conducts outreach to Participating Pharmacies to reverse previously adjudicated claims that have been identified with a retroactive ESRD date of service, or claims where insulin is used in a pump. The Participating Pharmacies must reverse the identified claim(s) and resubmit to the Covered Person's correct Medicare Part A or Part B coverage. If the Participating Pharmacy fails to reverse the claim as directed, Prime will reverse the claim on their behalf.

If a Participating Pharmacy erroneously bills Medicare Part D for a drug where coverage is available under Medicare Part A or Part B, Prime will recoup any money incorrectly paid through the pharmacy audit process and notify 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 to add or delete drugs.

Under 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 Drug 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 Drug 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 lists are posted on Prime's Website on a monthly basis.

During the benefit year, Prime will notify affected Covered Persons and Prescribers of Drug Formulary changes at least 60 days before the change becomes effective. Changes will also be posted on Prime's Website. These changes may include:

- Drugs that are removed from the Drug Formulary
- Changes to prior authorization, quantity limits and/or step therapy programs to be more restrictive
- Drugs that have moved to a higher cost-sharing tier

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 Drug Formulary and provide notice to Covered Persons who have received the drug.

Covered Persons may be notified of Drug Formulary changes by United States mail, email or when they check their plan's website. Prescriber and Participating Pharmacy Drug 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 PAs used by Prime:

- **One-time override** – Used for a dosage change, vacation, lost/stolen, spilled, incorrect days' supply, damaged medication or retail to mail. At the time of the fill, the Participating Pharmacy must document the reason for the override on the hard copy or within an electronic system. Electronic notes are only considered acceptable documentation when the Participating Pharmacy's system automatically dates and time stamps the entry. The Participating Pharmacy may request PA for a dosage change or vacation request by calling Prime's Contact Center at 800.821.4795.

- **Drug Formulary exception** – Used for Covered Persons sensitive or unresponsive to the Drug Formulary medication requested by the Prescriber. If the Benefit Sponsor has elected to use this PA, Prime will provide the Participating Pharmacy POS messaging for additional instructions on requesting a Drug Formulary exception. There are three ways to obtain a Request for a Drug Formulary Exception form:
  - The Prescriber can contact the Benefit Sponsor by phone or in writing based on the information provided on the Covered Person’s Identification Card.
  - The Covered Person can call the Covered Person service toll-free number on the back of the Covered Person’s Identification Card.
  - The Covered Person can visit their Benefit Sponsor’s website.
Section 3: Claims Processing (Continued)

• **Clinical PA** – 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 PA request to determine if the Covered Person is eligible for coverage. In these cases, Prime requires clinical documentation from the Prescriber. Regardless, Covered Persons should always contact the service department at their Benefit Sponsor if they have any questions. Examples of medications included in the clinical PA 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 PA. For the most current information on medication that requires PA, visit the Covered Person’s Benefit Sponsor’s website.

• **Dynamic PA** – Some Benefit Sponsors use an automatic override process referred to as dynamic PA. A Participating Pharmacy enters a pre-determined PA 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 PA for a dosage change or vacation override.

• **Appropriate Payor verification** – This PA is used specifically for certain drugs (e.g. Cialis and fentanyl) in Medicare Part D that have the highest likelihood of non-Medicare Part D covered uses. Claims for these drugs should reject at the POS and require a PA to determine that:
  › The Covered Person’s use of that drug is eligible for coverage under Medicare Part D and
  › 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 the transition period, the Covered Person will not immediately receive a temporary supply of these drugs as a Covered Person would for other drugs that are covered under Medicare Part D. Following Prime’s review of a PA request for one of these drugs, Prime may determine that the Covered Person’s use of that drug is covered under Medicare 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 the Covered Person’s transition period.

• **Hospice PA** – CMS has determined 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
  › 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 PA 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 Prescriber can follow the standard coverage determination process to request a Hospice PA. Additionally, the Hospice Care provider can submit a Hospice PA Form on the Covered Person’s behalf to request the Hospice PA.
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 Participating Pharmacy due to this incorrect eligibility, a Hospice PA 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’s Prescriber can submit a coverage determination or the Hospice Care provider can submit the Hospice Prior Authorization Form in order to request the Hospice PA. The Participating Pharmacy may request a Hospice PA Form by calling Prime’s Contact Center at 800.821.4795.

Electronic Submission of Prior Authorization Requests supported by CoverMyMeds

Prime partners with CoverMyMeds to enable electronic submission of PA requests for Prime’s Commercial, Medicare and Medicaid Covered Persons. For more information on CoverMyMeds, please visit: https://www.covermymeds.com/main/support-center/prescribers-pharmacist-support/

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 Drug Formulary to determine if a drug is subject to step therapy. Examples of medications that may be included in step therapy programs include ARBs/rein 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 PA.

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.

This section titled “Quantity Limit” does not apply to Prescription Drug Services where Pharmacy receives a rejection message at the POS indicating “Prior Authorization Required”, “Call Pharmacy Help Desk” and/or “Plan dollar limit exceeded”.

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 the Pharmacy 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
- Apparent Drug Misuse screening

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

Prime’s concurrent DUR edits during the claim submission and adjudication process are important steps toward complying with CMS regulations; however, 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 and refer to the Covered Person’s allergy information before dispensing. In addition, Participating Pharmacies must ensure that all employees or other agents who dispense medication are aware of and use these DUR procedures, and that they 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 Pharmacy 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’s Pharmacy Participation Agreement.
Section 4: Benefit Plan

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 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.

Long-Term Care (LTC) Guidelines

For Participating Pharmacies providing Prescription Drug Services to Covered Persons residing in an assisted living facility or other forms of congregate residential setting, the Covered Person must meet the same institutionalized level of care as a Covered Person residing in an LTC facility in order to be eligible for LTC reimbursement. At the time of dispensing, the level of care must be documented on either the prescription hard copy or the electronically submitted prescription.

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

PSC 1: Prime encourages Participating Pharmacies to dispense generic drugs whenever possible. However, there are instances where the Prescriber may request that a brand-name product be dispensed instead of the generic equivalent drug. 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.

PSC 2: 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 Drug Formulary as indicated by the claims system response and other correspondence, or the generic Drug 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.
Section 4: Benefit Plan

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.

**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 Covered Persons into the MTM program who meet specific criteria. Eligible Covered Persons can complete a CMR by contacting Prime’s Contact Center at 866.686.2223.

**Medicare Part D Transition Process**

CMS requires that Medicare 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 Medicare Part D Benefit Sponsor’s Drug Formulary
- Current drug therapies 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 get a Drug Formulary exception or PA.

**Prescription Drugs Not on Medicare Part D Benefit Sponsor’s Drug Formulary or Subject to Certain Limits**

When Covered Persons in their transition period (i.e., within 90 days of their eligibility) present a prescription for a drug that is not on the Medicare Part D Benefit Sponsor’s Drug Formulary and is not excluded from coverage by CMS, the paid transition claim will return the applicable NCPDP code 004 to the Participating Pharmacy explaining the drug paid due to the transition benefit.

**Supply Limits**

If the claim is submitted for a days’ 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 will explain the reason. Messaging examples are provided below.

At retail, Covered Persons will be limited to at least a 30-day transitional fill of a non-formulary drug or a drug subject to certain limits. LTC Covered Persons are allowed up to a 31-days’ supply per fill to a maximum of at least 98-days’ supply with multiple fills, during their transition period. The 98-days’ supply maximum takes into consideration those drugs that require Short Cycle Dispensing. (Refer to section, “Medicare Short Cycle Dispensing LTC Guidelines and Procedures”). The exception to the days’ supply limits 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).

Participating Pharmacies, including Extended Supply Network (ESN) and Mail Order pharmacies, must remember that they may get a reject message indicating that a Covered Person may not obtain more than the days’ 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 days’ supply to accommodate the transition days’ supply limit; 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 days’ supply limit, at that time the days’ supply should be reduced.

Partial Fills

Since Covered Persons may have received a partial fill during their transition period, it is important to check their history for the drug by NDC to see if you can provide the remainder of their transition supply.

For instance, in the retail setting a Covered Person may have received a 9-day transition supply. He/she is still eligible for the remaining 21 days under the transition benefit during the transition period.

Important Notice —To meet CMS requirements, Covered Persons in transition must not leave the Pharmacy without their medications as a result of a days’ supply limitation. Covered Persons who continue enrollment in a Medicare Part D Benefit Plan are eligible for a transition benefit within the first ninety (90) days of the new year. Prime will provide a transition process consistent with the transition process required for new enrollees beginning each new year or make a transition prior to the beginning of the new contract year.

Status Alerts

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. In these cases, Prime will use standard NCPDP codes indicating the payment of a claim is due to the transitional benefit. The standard transition benefit NCPDP code is 004. Pharmacists receiving this code 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 Drug Formulary exception or PA. Covered Persons will receive a letter from the Benefit Sponsor notifying them how to proceed in transitioning to a Formulary Drug or request a Drug Formulary exception or PA.

Sample POS Messaging

Here are some examples of RETAIL POS messaging during the transition period:

- If the claim is rejecting because the days’ supply being submitted is greater than the allowed days’ 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 1.800.821.4795.”
- 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 days’ supply being submitted is greater than the allowed days’ 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 1.800.821.4795.”
- When there is a paid claim the NCPDP code “004” will be returned indicating:
  - “FILLED IN TRANSITION BNFT.”
Section 4: Benefit Plan (Continued)

Additional benefits that apply to Covered Persons transitioning to/from LTC are as follows:

- The level of care change benefit applies to Covered Persons who switch care settings from LTC to retail or from retail to LTC. Early refill edits are not used to limit appropriate and necessary access to their Part D benefit, and such Covered Persons are allowed to access a refill upon admission or discharge. When there is a paid claim the NCPDP code “012” will be returned indicating:
  › “LEVEL OF CARE CHANGE”

- The emergency benefit applies to Covered Persons who are in LTC and may not be aware of non-formulary or PA/ST/QL limits that apply to drugs they are prescribed. Up to a 31-day emergency supply of these Part D drugs is allowed. When there is a paid claim the NCPDP code “008” will be returned indicating:
  › “EMERGENCY FILL SITUATION”

Refer to Prime’s Website for Drug Formulary listings.

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 LTC Guidelines and Procedures

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

- Claims must be billed in 31-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.
- OTC products: must be dispensed in the original container.
  › 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, the Participating Pharmacy shall maintain a delivery log to acknowledge delivery. The delivery log should include the following:
  › The prescription number
  › Date of fill
  › Delivery date and signature of Covered Person(s) receiving medication
  › Receipts and other documentation showing the Copayment (if applicable) was paid by the Covered Person or their representative

For the most up-to-date processing requirements for LTC, please visit Prime’s Website.

Medicare Short Cycle Dispensing LTC 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 short cycle claim (SCC) combinations.

The following fields must be submitted on all LTC SCCs:
- 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. Go to NCPDP’s website at NCPDPOnline.org to submit adds, changes, deletes, current address, fax number and phone number.

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

OIG/GSA Exclusion Checks

CMS requires that all individuals and businesses that contract to provide Medicare Prescription Drug Services 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 health care programs. As required, exclusion checks must be conducted prior to contracting or hiring and monthly thereafter. If a Participating Pharmacy or a specific Participating Pharmacy location is sanctioned by the OIG and excluded from participation in federal health care programs, the Participating Pharmacy must notify Prime immediately. 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’s 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’s 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 FWA as required by 42 CFR § 423.504, and to ensure that Medicare Covered Persons only receive new prescriptions and refills as requested. CMS and Medicare Part D Benefit Sponsors received many consumer complaints of unneeded prescriptions being sent as part of auto-ship refill programs.

This does not apply to retail or LTC Participating Pharmacies that have refill reminder programs that require the Covered Person to pick up the prescription.
Section 5: Responsibility of Participating Pharmacy (Continued)

Participating Pharmacies are required (when instructed through POS messaging) to include a copy of the “Medicare Prescription Drug Coverage and Your Rights” document with the Covered Person’s prescription order. To print a copy of this CMS-required document (in English or Spanish), please visit Prime’s Website.

Participating Pharmacies 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 Pharmacies must cooperate with the removal or revision of the communication.

Pharmacy Credentialing

Prime credentials pharmacies prior to entry into Prime’s Pharmacy Networks. A new pharmacy must complete a credentialing exhibit and supply all of the supporting documents so Prime can review and process the application. Prime re-credentials all Participating Pharmacies at least once every three years in accordance with applicable law and contractual obligations. Re-credentialing is a requirement for continued participation in Prime’s Pharmacy Networks. Failure to complete the re-credentialing exhibit will be cause for termination.

All Participating Pharmacies must provide Prime with copies of the following documents on an annual basis:

- Pharmacy License
- Pharmacist In Charge License
- DEA Certificate
- Certificate of Insurance with proof of General and Professional Liability Insurance

Participating Pharmacies must include their pharmacy name and NCPDP number on each of the documents.

Long-Term Care (LTC) and Home Infusion (HI) Annual Validation Process

In order for Prime to maintain the integrity of our HI and LTC Pharmacy Networks, Prime requires each Participating Pharmacy that participates in our HI and LTC Pharmacy Networks to validate on an annual basis that they are able to continue to comply with guidelines outlined for participation in the HI and/or LTC Pharmacy Networks.

For your convenience, the validation form is available on Prime’s Website with required guidelines for participation in the HI and LTC Pharmacy Networks.

Failure to validate may result in termination from the HI or LTC Pharmacy Networks.

Termination Appeals

Participating Pharmacies have thirty (30) days from the date of notification of termination or an extended time from as required by law to submit an appeal. Appeals must be submitted in writing and include the Participating Pharmacy’s name and an explanation of the appeal. Terminations will be deemed finalized if an appeal is not received by Participating Pharmacy within the thirty (30) days from the date of notification of the termination or an extended time frame as required by law or regulation. 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 a Participating Pharmacy from Prime’s Pharmacy Network(s) for up to five years, depending on the reason for termination.
Confidentiality and Proprietary Rights

Confidentiality

Any information or data obtained from, or provided by, Prime or any Benefit Sponsor to the Participating Pharmacy is highly confidential. This includes, but is 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 and related Exhibits or other Prime documents.

- 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 or any information obtained through performance of the Agreement 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

Audits

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’s Pharmacy Participation Agreements and this Manual. Audits verify the integrity of claims submitted to Prime and Pharmacy Payments made to the Participating Pharmacy. They also confirm the accuracy of claim information submitted to identify instances of potential FWA.

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 Pharmacy Payment Recoupment, 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 FWA
- 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 its records related to Prescription Drug Services provided under the Agreement. This includes, but is not limited to:

- Wholesaler invoices
- Prescription orders
- Signature log/delivery log
- Licensing
- Proof of insurance

During an audit, Prime uses these records to compare the submitted claims information to the original source documentation, such as the prescription orders and other relevant documentation to confirm the accuracy of the claim.
Section 6: Participating Pharmacy Audit (Continued)

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.

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 the Prescription Drug Service for commercial claims, and up to ten (10) years from the date of Prescription Drug 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. Results include details of any issues of non-compliance with:

- Federal and state regulations
- The Pharmacy Participation Agreement
- Prime's Provider Manual
- 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 Prime's Pharmacy Network(s) upon Prime's receipt of any evidence of a Pharmacy participating in activities that may result in FWA.

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. After the review of the claim and/or prescription order, if 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 Copayment (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 NDC’s and quantities used to prepare the compound claim
- 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

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
- 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.
Section 6: Participating Pharmacy Audit (Continued)

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

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

- Original prescriptions, front and back
- Prescription label
- Signature or delivery logs
- Receipts and other documentation showing the Copayment (if applicable) paid by the Covered Persons or their representatives
- Tracking number from delivery log, which 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 used to prepare the compound claim
- 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 person 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, may be photographed or copies will be requested by the auditor as necessary.

When the audit is complete, the auditor will provide general feedback verbally. Prime will provide the Participating Pharmacy with a written audit report, which will include details of any discrepancies or relevant audit findings.

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
- 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.

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.

- 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. The instruction: “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. 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 administrated 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.
Section 6: Participating Pharmacy Audit (Continued)

- **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 missing one or more of the required elements may be considered invalid and subject to audit recovery.

**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 Identification Card 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 is 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 drug, 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. If the POS messaging claim requires a PA, the Participating Pharmacy must follow POS messaging and not reduce the quantity. In order to prompt accurate POS messaging, the Participating Pharmacy must accurately represent the days’ supply based on the quantity dispensed and directions for use on the prescription order.
Section 6: Participating Pharmacy Audit (Continued)

• **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 based on the quantity dispensed and the directions of use on the prescription order. 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.

Prime requires Participating Pharmacies to obtain patient consent prior to enrolling a prescription in auto-ship refill programs. This is in an effort to control FWA and ensure Prime’s Covered Persons only receive new prescriptions and refills as requested.

• **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 PA (override or DUR override) numbers or clarification code. Inappropriate use or lack of supporting documentation related to dynamic PA’s or clarification codes 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. 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. Claims not reversed after fourteen (14) days may be subject to audit recovery.
• **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.

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 that may lead to the inappropriate bypass of benefit exclusions, DUR messages, or other Benefit Plan edits.

• Billing for a quantity of a legend drug that 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 Federal 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 Medicare Part A or Part B eligible drugs to a Medicare 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 and patches).

• Pharmacies may not solicit Covered Persons or obtain a third party to solicit Covered Persons for prescription orders.
Section 6: Participating Pharmacy Audit (Continued)

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. Audit findings, including recoveries, will be deemed finalized if an appeal is not received by Participating Pharmacy within the thirty (30) days from the date of notification of the audit findings or an extended time frame as required by law or regulation. 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.
Section 7: Medicaid Requirements

General Medicaid Program Inquiries

For general inquiries related to the Medicaid Programs please call:

- BCBSMN Blue Plus: **800.821.4795**
- BCBSIL Family Health Plan: **855.457.0173**
- BCBSIL Community ICP: **888.274.5218**
- BCBSNM Community Centennial: **855.699.0040**
- BCBSTX Children’s Health Insurance Program (CHIP): **855.457.0403**
- BCBSTX State of Texas Access Reform (STAR): **855.457.0405**

General Medicaid Requirements

Pharmacy Disclosure Statement

Participating Pharmacies who participate in Medicaid Programs must complete a Pharmacy Disclosure Statement in order to comply with federal and/or state regulations. Participating Pharmacies must complete Prime’s Pharmacy Disclosure Statement when requested and notify Prime of any changes in ownership when they occur.

Minnesota Medicaid Requirements

Automatic Refills

Minnesota Health Care Programs (MHCP) does not allow automatic refills for Medicaid members. The Participating Pharmacy may not contact the recipient in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the recipient’s medication regimen. Prescription refills are not eligible for payment without an explicit request from a recipient or authorized caregiver.

A Prescribing Provider or other authorized agent of a facility may initiate a request for refill for a recipient residing in a skilled nursing facility, group home, or assisted living arrangement.

Do Not Accept Cash Payment

As a general reminder, Participating Pharmacies may not accept cash payment from a Covered Person, or from someone paying on behalf of the Covered Person, for any MHCP covered prescription drug.

A Participating Pharmacy may accept cash payment for a non-covered prescription drug provided that:

- The Covered Person is not enrolled in the restricted recipient program
- All available covered alternatives have been reviewed with the Covered Person
- The Participating Pharmacy obtains a Covered Person signature on the MHCP Acknowledgement form
- The prescription is not a controlled substance (except phentermine in certain circumstances) tramadol or gabapentin

A Participating Pharmacy may only accept a cash payment for a controlled substance, tramadol or gabapentin, if the Pharmacy has received authorization from MHCP to do so on the date of service. To be considered for cash payment authorization, the Prescribing Provider must contact the MHCP help desk at 800.366.5411 and provide rationale as to why the covered alternatives are not viable options for the Covered Person.

If a Covered Person’s MHCP eligibility status is in question and the Covered Person offers a cash payment for prescriptions, the Participating Pharmacy must verify eligibility through Minnesota Information Technology Services (MN-ITS) or Eligibility Verification System (EVS). If the person does not have coverage through MHCP you can accept cash as payment.

For further information on Minnesota’s Medicaid regulations visit Minnesota Department of Human Services.
Texas Medicaid Requirements

Prime is the pharmacy benefit manager for Blue Cross and Blue Shield of Texas, a managed care plan that provides services for Covered Persons in the Texas Medicaid plans. The terms and conditions of this section titled “Texas Medicaid Requirements” shall apply to Participating Pharmacies that provide Prescription Drug Services to Covered Persons in the Texas Medicaid Network.

National Provider Identifier (NPI)

The Participating Pharmacy must submit the Prescriber’s NPI for all Medicaid claims.

Pharmacy Credentialing

For entry into the Texas Medicaid Network, pharmacy must fill out a credentialing application and provide the following documents:

- Pharmacy license number
- Pharmacist in Charge license number
- DEA Certificate
- Certificate of Insurance with proof of General and Professional Liability Insurance

Within fifteen (15) days of receiving a fully completed credentialing application from the pharmacy, Prime will assess and verify that the pharmacy name, pharmacists and the pharmacy owner are not excluded or debarred based on a search on the SanctionsBase tool. Prime uses the Texas State Board of Pharmacy website as the primary source of validation to verify that all pharmacy and pharmacists license are active, and no disciplinary actions exist on file. If a disciplinary action is found, Prime will conduct further assessment.

All Participating Pharmacies in the Texas Medicaid Network must provide Prime with the documents listed above on an annual basis.

Documentation

Specific to the Texas Medicaid program, verbal changes and clarifications to the Prescriber’s prescription order must be documented on the original hard copy or electronically noted in the Participating Pharmacy’s online system prior to dispensing. The Participating Pharmacy will request the Prescriber obtain a PA. Electronic documentation must be noted prior to dispensing and must 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.

Compound Drugs Billing Guidelines

Participating Pharmacies must submit compound drugs through the Prime 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.
Section 7: Medicaid Requirements (Continued)

- Submit the total ingredient cost, including OTC ingredients: 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.
  - Plan-excluded drugs and invalid NDCs are not eligible for reimbursement.
  - Eligible OTC ingredients may be covered by the benefit plan.
  - 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 using NCPDP's compound segment for up to 25 ingredients.
- The Participating Pharmacy must submit the submission clarification code of “08” for all compounds to allow payment of all covered ingredients, including OTC products. The Participating Pharmacy must follow POS messaging to determine if the ingredients submitted requires a PA prior to submitting the “08” clarification code.

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.

The following are examples of compound drugs that benefit design may not cover:
- Modified-release compounds (based on Covered Person 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.
- 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.

The following drugs cannot be submitted to Prime as a compound drug:
- Reconstituted non sterile products, to which only water, alcohol or sodium chloride solution are added to the active ingredient (for example, children’s antibiotic suspensions).
- Any prescription that is subdivided into unit dose(s).
- Injectable drugs that are drawn into syringes for administration.
- 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.
- Obtaining changes to prescription orders to avoid POS messaging.
- Billing claims in a manner that bypasses system messaging requiring further review.
  - Example: billing claims multiple times in a month to avoid obtaining a PA or reaching plan dollar thresholds.

If you have questions regarding compound drugs please contact Prime’s Contact Center for STAR Covered Persons at 855.457.0405 and for CHIP Covered Persons at 855.457.0403.

**Maximum Allowable Cost (MAC) and Appeals**

For a drug to be placed on Prime’s Texas Medicaid MAC list the drug must be “A” or “B” rated in the most recent version of the United States Food and Drug Administration’s Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an “NR” or “NA” rating or a similar rating by a nationally recognized reference; and be generally available for purchase by pharmacies in the state of Texas from national or regional wholesalers, and is not obsolete.

Prime’s MAC pricing is reviewed a minimum of once every seven days to ensure the MAC price of every drug is based on the current market price of available therapeutically equivalent drugs. A network pharmacy provider may challenge a listed MAC price for a drug by submitting an invoice and claim information of the MAC drug being appealed. Prime will respond to a challenge no later than the 15th day after the date the challenge is made. If the challenge is successful, the MAC price for the drug will be adjusted on the date the challenge is resolved, and will be applicable to all similarly situated network pharmacy providers as determined by Prime. If the challenge is denied, Prime will provide a reason for the denial.

If a participating network pharmacy provider 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 network pharmacy provider will receive a secure user name and password via email to access Prime’s MAC list(s).

**Prescription Drug Benefits**

Prime uses the Texas Vendor Drug Program Preferred Drug List.

**How to use the Drug Formulary**

The Drug Formulary lists the brand name or generic name of a given drug. If a medication does not appear on this Drug Formulary, the medication is not covered under the pharmacy benefit. In some instances, a medication may require a PA. A PA form should be completed by the Prescriber and submitted to Prime before the prescription may be filled. To obtain the PA form for medications requiring PA, please contact Prime’s Contact Center for STAR Covered Persons at 855.457.0405 and for CHIP Covered Persons at 855.457.0403.

You may search the Drug Formulary at the Texas Vendor Drug Program or through Epocrates.
Section 7: Medicaid Requirements  (Continued)

Prior Authorization (PA)

PA is designed to encourage appropriate use of medications. Select medications may require a PA. Medication utilization must meet FDA-approved indications, as well as Prime’s medical necessity guidelines. The Participating Pharmacy should not request changes to a prescription for the sole purpose of avoiding POS messaging. For example, if a Participating Pharmacy receives a POS message indicating a PA is required or that it must call Prime’s Contact Center, the Participating Pharmacy is expected to follow the POS messaging and Prime’s Contact Center instructions. Participating Pharmacy may contact the Prescribing Provider for further clarification or additional information about the prescription as needed. If a medication requires PA, a PA form should be completed by the Prescriber for submission to Prime. To obtain a PA form Participating Pharmacy may contact Prime’s Contact Center for STAR Covered Persons at 855.457.0405, for CHIP/CHIP Perinate Covered Persons at 855.457.0403 for more information or through CoverMyMeds at pharmacySystems.covermymeds.com. All PA fax forms may be submitted via fax to 877.243.6930.

Emergency Prescription Supply

A Participating Pharmacy will receive a rejection of “PA Required” for a non-preferred drug that has not been prior authorized. The message will indicate that the drug is non-preferred and that the Prescriber should call Prime’s PA line at 888.216.6710 to initiate a PA request.

If Participating Pharmacy is unable to override, Prime’s Contact Center is available 24 hours/7 days a week to provide assistance:

STAR Pharmacy Contact Center at 855.457.0405
CHIP Pharmacy Contact Center at 855.457.0403

In emergency situations, after hours or on weekends, Participating Pharmacies are authorized to dispense a 72-hour emergency supply of any non-preferred medication without prior approval. Participating Pharmacies should submit an “8” in field 461 EU (Prior Authorization Type Code) and code “801” in field 462 EV (Prior Authorization Number Submitted), and a ‘3’ in Field 404 D5 ‘Days Supply’ in the claim segment of the billing transaction. The quantity dispensed and submitted in Field 442 E7 ‘Quantity Dispensed’ should equal the quantity necessary for a 3-day supply according to the directions for administration given by the Prescriber.

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and PA is not available. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member’s medical condition. If the Prescriber cannot be reached or is unable to request a PA, the Participating Pharmacy should submit an emergency 72-hour prescription.

A Participating Pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply. The 72-hour emergency supply is not applicable if PA denial is on record.

Quantity Supply Limits

BCBSTX allows up to a 34-day supply of medication. This program defines a standard 34-day supply of medication for a select list of medications. If a medical condition warrants a greater quantity supply than the defined 34-day supply of medication, a PA will ensure access to the prescribed quantity. Prior to dispensing, a PA needs to be submitted to Prime to determine medical necessity.
Section 7: Medicaid Requirements  (Continued)

Dose Optimization

The Dose Optimization Program, or dose consolidation, is an extension to the Quantity Supply Program, which helps increase patient adherence with drug therapies. This program works with the Covered Person, the Covered Person’s physician or health care provider, and the pharmacist to replace multiple doses of lower strength medications where clinically appropriate with a single dose of a higher-strength medication (only with the prescribing physician’s approval). Prior to dispensing of multiple doses of the lower strength medications, a written PA needs to be submitted for an internal review by Prime to determine medical necessity.

Benefit Exclusions

Benefit exclusions are those services that are not covered under the Covered Person’s benefit plan which include the following medications:

- Infertility medications
- Erectile dysfunction medications
- Cosmetic and hair growth medications
- Dietary supplements
- Drugs not approved by the FDA
- Over the counter drugs for CHIP/CHIP Perinate Covered Persons
- Contraceptive agents used for family planning for CHIP/CHIP Perinate

Where Prescription Drug Services are Filled

Prescription Drug Services can be filled at pharmacies participating in the Texas Medicaid Network. A listing of these pharmacies in the Texas Medicaid Network can be found in the BCBSTX Provider Directory. To verify pharmacy network participation or BCBSTX drug coverage, please call the help desk for STAR at 855.457.0405 and for CHIP/CHIP Perinate at 855.457.0403.

Retail pharmacies can dispense no more than a 34-day supply, but most prescriptions can be written with refills.

Prime’s Information for Claims Processing:

BIN 011552
PCN TXCAID

The Group# is not required for STAR and CHIP claims processing.

Member Eligibility

A Participating Pharmacy should verify the Covered Person's Medicaid coverage at the time of service. A Participating Pharmacy can verify eligibility by calling the Texas Medicaid Healthcare Partnership (TMHP) at 1.800.925.9126 or go to TexMedConnect on the TMHP website and checking the Covered Person's Medicaid ID number (PCN).

Covered Persons may call BCBSTX customer service at 888.657.6061 with eligibility-related questions. If a Covered Person is unaware of which program he/she is enrolled in, the Covered Person may contact the Medicaid Managed Care enrollment broker. Covered Persons may call the Medicaid Client Line at 800.964.2777 for assistance with eligibility-related issues.
Section 7: Medicaid Requirements  (Continued)

Cost to Member

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<tr>
<th>Member Type</th>
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</thead>
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<td>STAR</td>
<td>No copay</td>
</tr>
<tr>
<td>CHIP &lt; 100% FPL</td>
<td>$0 for generic/$3 for brand</td>
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<td>CHIP 101 – 150% FPL</td>
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<td>CHIP 151 – 185% FPL</td>
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<td>CHIP 186 – 200% FPL</td>
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<td>No copay</td>
</tr>
<tr>
<td>CHIP No Cost Share</td>
<td>No copay</td>
</tr>
</tbody>
</table>

Tuberculosis (TB)

Covered Person(s) who may be or are at risk for exposure to TB must be screened for TB. An at-risk Covered Person(s) means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions. The Participating Pharmacy must consult with the local TB control program to ensure that all services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), the Centers for Disease Control and Prevention (CDC), and Texas Department of State Health Services' (DSHS) policies and standards.

Advance Directives

Participating Pharmacy must comply with the requirements of state and federal laws, rules and regulations relating to advance directives and in accordance with 42 C.F.R. §489, Subpart I.

Child Protection

Participating Pharmacy must testify in court as needed for child protection litigation if requested by Texas Health and Human Services Commission (HHSC).

Cancellation of Product Orders

In the event a Participating Pharmacy in the Texas Medicaid program offers delivery services for covered product(s), such as durable medical equipment (DME), home health supplies, or outpatient drugs or biological products, and the Covered Person requests in written or oral representation to reduce, cancel, or stop delivery of the covered product(s), Participating Pharmacy must maintain records documenting the request.

Coordination of Benefits

Participating Pharmacy must perform Coordination of Benefits in accordance with HHSC Uniform Managed Care Manual, Chapter 3.3 Section VI, C and HHSC Uniform Managed Care Pharmacy Claims Manual, Chapter 2.2 Section VI, A.

Important Toll-free Contact Numbers

Prime’s Contact Center is available 24 hours/7 days a week:

- BCBSTX CHIP: 855.457.0403
- BCBSTX STAR: 855.457.0405

Pharmacy prior authorization voice is available 24 hours/7 days a week:

- BCBSTX CHIP and STAR: 888.216.6710
- Pharmacy prior authorization fax: 877.243.6930

Blue Cross Blue Shield Provider customer service:

- 877.560.8055