Prime Perspective

Prime Perspective provides information and updates about Prime services

June 2025: Issue 93

Inside

Fraud, waste and abuse (FWA) updates

Proper billing of long days' supply

Pharmacies billing for medications are required by Prime Therapeutics (Prime) to employ the use of proper days' supply according to the prescribed use of the product. If a rejection message to bill for appropriate benefit allowance occurs, only then shall a Pharmacy utilize a shorter duration days' supply. Subsequent fills should consider the actual days' supply dispensed in the previous fill.

Illegal remuneration schemes

Participating Pharmacies and Prime have an obligation to help protect and maintain the integrity of the health care system by reporting and not participating in illegal remuneration schemes, also known as kickbacks. This includes Participating Pharmacies offering, soliciting or receiving unlawful payments that result in an incentive or reward for switching covered persons to different drugs, influencing prescribing providers to prescribe different drugs, or steering covered persons to specific health plans.

Prime expects all Participating Pharmacies to adhere to standards set forth in the Provider Manual, including prohibiting the steering of covered persons to specific health plans. Pharmacies found in violation of this may be subject to disciplinary action.

Follistim AQ package size change

Follistim AQ is now manufactured by Organon & Co. This change in manufacturer resulted in new quantities that should be utilized for adjudication. The following is a chart of National Drug Codes (NDCs) and quantities per cartridge:

Drug strength	NDC	Quantity per cartridge
Follistim AQ 300 IU	78206-0129-01	0.36 ml
Follistim AQ 600 IU	78206-0130-01	0.72 ml
Follistim AQ 900 IU	78206-0131-01	1.08 ml

Please ensure that the quantity billed is appropriate based on the NDC and number of cartridges dispensed.

Billing compounding errors

The system accepts multi-ingredient compounds in the compound segment of the B1 transaction. Only one compound claim is allowed per transmission and cannot be included as part of a multiple claim transaction. All ingredients of each compound must be submitted, and the system will only reimburse for products on the program-specific formulary.

Pharmacy providers submitting claims for compounding pharmacy products may bill for compounding services using the online claims adjudication system. The pharmacy provider will use National Council for Prescription Drug Programs (NCPDP) field number 474-8E (DUR/PPS Level of Effort) to enter the appropriate value. The values for this field and resulting compounding fee are as follows:

Value	Number of minutes
11	15 minutes
12	30 minutes
13	45 minutes
14	60 minutes

The compounding fee is paid based on the level of effort of the product compounded. The maximum number of minutes to be billed is indicated in the chart below. For dosage forms not included in the chart, pharmacy providers should document actual time spent preparing the compounded product and bill accordingly. No more than 60 minutes of compounding time will be allowed for any single preparation.

Minutes	Type of product/dosage form
15	• Oral solutions or suspensions involving the combination of commercially available oral products • Topical preparations compounded by combining commercially available topical products • Enemas
30	• Suppositories • Compounded capsules • Topical preparations containing components that are NOT commercially available in a topical formulation
45	• Oral liquids containing components that are NOT commercially available in oral formulation • Ophthalmic preparations • Chemotherapeutic topical agents
60	• Sterile injectable preparations

Prime expects all compounds to be billed with the proper intent of being used towards effective treatment where literature is supported using clinical use. Utilizing products in a compounded manner where they will not be absorbed or beneficial for the treatment will be deemed unnecessary. Pharmacies are expected to observe applicable state and federal laws, relevant U.S. Pharmacopeia (USP) Chapter Guidelines, professional standards and FDA communications when preparing and dispensing compound prescriptions. Evidence of unprofessional or unsafe compounding found during the Pharmacy's audit process or otherwise may be subject to remedial actions.

Pharmacy audit information

Please visit **PrimeTherapeutics.com/Providers-and-Physicians** for more information regarding pharmacy audits, including common billing errors, pharmacy audit appeals and pharmacy audit guidelines.

Medicare & Medicaid news

Medicare Prescription Payment Plan (M3P)

As part of your respective Participation Agreement and Prime's Provider Manual, Pharmacies are required to abide by all applicable federal and state laws, including those requirements associated with M3P. This includes, but is not limited to:

- Ensuring that eligible Medicare Part D members receive the appropriate Likely to Benefit Notice provided by the Pharmacy based on CMS requirements
- Proper training being provided to pharmacy staff surrounding M3P, such as continuing education credits, webinars and educational materials
- Documentation or oversight measures are in place to ensure proper adherence to the M3P provider requirements on Prime's website

Pharmacies are expected to comply with all CMS-defined requirements for the M3P program.

Prime will return Approved Message Code 056 "Beneficiary likely to benefit from Medicare Prescription Payment Plan" on all Medicare Part D claims where the member's out-of-pocket cost meets or exceeds the CMS-defined threshold. When Approved Message Code 056 is returned, Pharmacies are responsible for providing the M3P Likely to Benefit Notice to the member at point of sale. Long-term care Pharmacies are to provide the notice to the Part D enrollee at the time of its typical enrollee cost-sharing billing process. If a member would like to participate in the program, they should contact the number on the back of their ID card.

In instances where the enrollee may choose to take time to consider opting into the program and leaves the Pharmacy without the prescription that triggered the notification, when the enrollee returns to the Pharmacy to pick up their prescription after opting into the program, the prescription claim that triggered the notification must be reversed and reprocessed. Then the coordination of benefits (COB) claim should be submitted for M3P processing.

After enrollment in the M3P program, should a Part D enrollee have other unpaid claims at the same Pharmacy for covered Part D drugs from dates of service prior to M3P eligibility, in addition to the prescription that may have triggered the Likely to Benefit notification, the covered person may request that those claims be reversed and reprocessed with current date, to be included in M3P.

When a Medicare Part D member is participating in the M3P program, and a Medicare Part D claim is processed where the member has an out-of-pocket cost, Prime will return Approved Message Code 057 "Beneficiary participating in Medicare Prescription Payment Plan," indicating that the M3P plan should be billed. The claims processing information for the member's M3P plan will be returned in the other payer information section of the claim response. The Pharmacy is responsible for using that information to bill a COB claim to M3P. M3P claims must be billed using the Other Payer Patient Responsibility Amount (OPPRA) method of COB processing. An Other Coverage Code of 8 should be used on all M3P claims. The final patient pay prior to the M3P claim should be submitted as a single amount with Other Payer Patient Responsibility Amount Qualifier 06 – Patient Pay Amount. For additional claims processing information, please see the M3P payer sheet.

In situations where a supplemental payer is billed after the Part D claim and before the M3P claim, if the supplemental claim returns a higher out-of-pocket cost than the Part D claim, the M3P plan will pay up to the Medicare Part D out-of-pocket cost, and the remainder will be a patient pay amount on the M3P claim that must be collected from the member unless they choose not to use their supplemental coverage.

Prime will return Reject Code DO3 "This claim is not eligible for Medicare Prescription Payment Plan" on M3P claims, in situations where the product was covered as an enhanced benefit and not a product defined as covered by the Medicare Part D core benefit. These claims cannot be billed to M3P.

Nothing in this guidance precludes a Pharmacy from educating a Part D member about this program, regardless of whether the Part D member's cost sharing reaches the point-of-sale threshold for required notification.

Pharmacies' responsibility to provide eligible M3P enrollees Likely to Benefit Notice

In pharmacy settings in which there is direct contact with enrollees (e.g., community Pharmacies where enrollees present in person to pick up prescriptions), the Medicare Prescription Payment Plan Likely to Benefit Notice must be provided to enrollees identified as likely to benefit (or the person acting on their behalf) at the time the prescription is picked up. This includes Pharmacies with a drive-through or curbside pickup option. If the Pharmacy is in contact with a Part D enrollee identified as likely to benefit and the enrollee declines to complete the prescription purchase, the Pharmacy must provide the Medicare Prescription Payment Plan Likely to Benefit Notice to the Part D enrollee. For example, if a Part D enrollee visits a retail Pharmacy to pick up their prescription but then declines to complete the transaction because of the cost, the Pharmacy must still provide the standardized Medicare Prescription Payment Plan Likely to Benefit Notice to that Part D enrollee.

In the case of long-term care Pharmacies, when the point-of-sale notification is received by a long-term care Pharmacy, it is required that the Pharmacy provide the Medicare Prescription Payment Plan Likely to Benefit Notice to the Part D enrollee (or their authorized representative) at the time of its typical enrollee cost-sharing billing process.

For other pharmacy types without in-person encounters (such as mail order Pharmacies), the Pharmacy must notify the Part D enrollee via a telephone call or their preferred contact method. This requirement should not, however, be interpreted as a requirement to delay dispensing the medication. Pharmacies are encouraged to utilize existing touchpoints with Part D enrollees, such as outreach to review medication instructions or collect a method of payment, to convey the content of the Medicare Prescription Payment Plan Likely to Benefit Notice prior to processing payment for the prescription that triggered the notice.

Medicare Part B coverage expanded for medications used to prevent human immunodeficiency virus (HIV)

The Centers for Medicare & Medicaid Services (CMS) expanded Part B coverage for drugs approved to prevent HIV with the finalization of a new National Coverage Determination (NCD) policy, "Pre-exposure Prophylaxis (PrEP) Using Antiretroviral Therapy to Prevent Human Immunodeficiency Virus (HIV) Infection." Effective the date the final NCD was issued, when used to prevent HIV in individuals at high risk of HIV acquisition, also known as HIV pre-exposure prophylaxis (HIV PrEP), the drugs listed below became eligible for coverage under Part B with no member cost share ($0.00) at an in-network provider.

- J0750 – Emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg (Truvada), oral, FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV); short descriptor: HIV prep, ftc/tdf 200/300mg
- J0751 – Emtricitabine 200 mg and tenofovir alafenamide 25 mg (Descovy), oral, FDA-approved prescription, only for use as pre-exposure prophylaxis (not for use as treatment of HIV); short descriptor: HIV prep, ftc/taf 200/25 mg
- J0739 – Injection, cabotegravir, 1 mg (Apretude), FDA-approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV); short descriptor: HIV prep, inj, cabotegravir

  Pharmacy action required
  Medicare patients using these drugs for HIV PrEP should no longer be processed under Part D and instead should be processed under Part B. Please note, when used for treatment of HIV or other supported uses, these drugs are still covered under Part D.

How to process under Part B

1. For patients with a Medicare Advantage Prescription Drug (MAPD) plan, **the Pharmacy will need to submit or reprocess the prescription claim using the following prior authorization code: 15151515151. This code will direct the claim to process under Part B.**
2. For patients with a Prescription Drug Plan (PDP) and separate Part B coverage, **the Pharmacy should process the prescription under the Medicare Part B plan.**
3. A diagnosis code is required to submit a Part B claim to Medicare. Ensure the active prescription includes an appropriate code. For example, Z29.81 Encounter for HIV pre-exposure prophylaxis. If the prescription does not include a diagnosis code related to the use of the drug, the patient or Pharmacy should request a new prescription that includes an appropriate diagnosis code prior to submitting under Part B.

To bill Part B, a Pharmacy needs to be enrolled with Medicare as a Part B pharmacy supplier or a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). If you have questions, please call the Pharmacy Help Desk.

Medical supplies associated with the delivery of insulin

Effective Jan. 1, 2025, Prime requires verification of insulin therapy when dispensing medical supplies associated with the delivery of insulin (syringes, gauze and alcohol swabs).

As stated in Chapter 6 of the Medicare Prescription Drug Benefit Manual, the definition of a Part D drug includes medical supplies associated with the injection of insulin.

All claims for medical supplies associated with the delivery of insulin, where the member does not have a historical claim for insulin in their previous medication history, will require a prior authorization code.

Action required

- NCPDP Reject Code 75: "PRIOR AUTHORIZATION REQRD"
- Secondary message: "IF USED FOR INSULIN ADMIN ENTER PA CODE 32132132132. OTHER USE NOT COVERED"

To help ensure a smooth transition, Participating Pharmacies are encouraged to assist covered persons with other options to help the member purchase needed medical supplies when not associated with the delivery of insulin.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)

Use of multiple anticholinergics in older adults is associated with an increased risk of cognitive decline. The Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults measure was endorsed by the Pharmacy Quality Alliance (PQA) in 2017 and adopted by the Centers for Medicare & Medicaid Services (CMS) as a Star measure for the 2025 measurement year. This measure is based on the American Geriatrics Society Beers Criteria®.
The American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults is a list of medication guidelines that help health care providers safely prescribe medications for adults over age 65. To ensure the safety of our members, Prime has implemented a DUR safety edit.

This point-of-sale safety edit, when triggered, will result in NCPDP Reject Code 88 and pass the below message.

Pharmacy messaging

- NCPDP Reject Code 88: "DUR Reject Error"
- Secondary message: "EVALUATE MUTLIPLE ANTICHOLINERGIC USE WHICH MAY BE UNSAFE OR UNNECESSARY. PPS CODES ACCEPTED TO OVERRIDE THE REJECT"

Specifications

Patients who are 65 years or older who have filled two or more prescription claims on different dates of service in the measurement period and at least 30 cumulative days of concurrent use. Patients receiving hospice care are excluded.

Anticholinergic medications table

a Includes combination products that contain a target medication listed and the following routes of administration: buccal, nasal, oral, transdermal, rectal and sublingual. Injectable and inhalation routes of administration are not included (not able to accurately estimate days' supply needed for measure logic). For combination products that contain more than one target medication, each target medication (active ingredient) should be considered independently.

b Source: Medications in this table are from Table 7 of the American Geriatric Society 2019 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.

c There are no active NDCs for dimenhydrinate.

d During the individual's measurement year, calculate a daily dose for each fill of doxepin with the following formula: (quantity dispensed x dose)/days' supply; For both denominator and numerator calculation, only include prescription claims for doxepin where the daily dose is >6 mg/day.

e Chlordiazepoxide is not a target medication as a single drug.

Antihistamine medications	brompheniramine chlorpheniramine cyproheptadine	dimenhydrinate[c] diphenhydramine (oral) doxylamine	hydroxyzine meclizine triprolidine
Antiparkinsonian agent medications	benztropine	trihexyphenidyl	
Skeletal muscle relaxant medications	cyclobenzaprine	orphenadrine	
Antidepressant medications	amitriptyline amoxapine clomipramine	desipramine doxepin (>6 mg/day)[c]	imipramine nortriptyline paroxetine
Antipsychotic medications	chlorpromazine clozapine	olanzapine perphenazine	chlorpromazine clozapine
Antimuscarinics (Urinary incontinence) medications	darifenacin fesoterodine flavoxate	oxybutynin solifenacin	tolterodine trospium
Antispasmodic medications	atropine (excludes ophthalmic) clidinium-chlordiazepoxide[d]	Dicyclomine Hyoscyamine	scopolamine (excludes ophthalmic) homatropine (excludes ophthalmic)
Antiemetic medications	prochlorperazine	promethazine	

Drug utilization review (DUR) therapeutic duplication misuse

Prime has observed a high volume of concurrent use of multiple GLP-1s and GLP-1 + DPP-4 amongst members. These combinations are not clinically supported, and use may result in adverse events and medication waste. To combat this problem, Prime is offering a duplicate therapy safety edit called Misuse. This program will monitor for members using the below medication combinations.

- GLP-1 + DPP-4
- GLP-1 + GLP-1
- DPP-4 + DPP-4
- SGLT-2 + SGLT-2

Plans will have the option to implement the Misuse safety edit in the fall of 2024 across all lines of business. The safety edit will reject a claim when the member has a history of using multiple drugs with the same therapeutic purpose filled with an overlapping day supply. The goal of this edit is to monitor and curb the combination use of GLP-1 + DPP-4, GLP-1 + GLP-1, DPP-4 + DPP-4, and SGLT-2 + SGLT-2. This point-of-sale safety edit when triggered, will result in NCPDP Reject Code 88 and pass the below message.

Pharmacy messaging

- NCPDP Reject Code 88: "DUR Reject error"
- Secondary message: "POTENTIAL DUPLICATE USE <<drug combo from above >>. INTERVENTION REQD TO EVALUATE DUAL USE. SUBMIT PPS CODES TO OVERRIDE."

To help ensure our members obtain their needed medications, this duplicate therapy reject can be resolved at the Pharmacy. The dispensing pharmacist should review the safety edit, and if the prescription is deemed appropriate, enter the corresponding combination of Professional Pharmacy Service (PPS) codes to override the rejection. Of note, additional utilization management edits such as prior authorization and/or quantity limits may still apply.

To help ensure our members obtain their needed medications, this duplicate therapy reject can be resolved at the Pharmacy. The dispensing pharmacist should review the safety edit and, if the prescription is deemed appropriate, enter the corresponding combination of PPS codes to override the rejection. Note: Additional utilization management edits such as prior authorization and/or quantity limits may still apply.

Refill Too Soon – Cumulative

Prime has expanded the DUR safety edit Refill Too Soon (RTS) – Cumulative to Medicare plans effective Jan. 1, 2025. RTS – Cumulative was developed as Prime observed a high volume of members stockpiling excessive amounts of medications which can lead to medication waste if a member discontinues or changes therapy. RTS – Cumulative is an ingredient duplication safety edit that rejects claims when the member has a history of refilling prescriptions early. If the member regularly refills medications a little early each fill, the extra quantity from each early refill is considered when determining if the "Refill Too Soon" reject should occur. A reject occurs when a covered person has accumulated more than the percentage allowed of medication on hand within a 180-day time frame.

Pharmacy messaging

- NCPDP Reject Code 943: "RxOverid DUR/PPS NotAllowd"
- Secondary message: "REFILL PAYABLE ON OR AFTER XX-XX-XX"

Example: Plan A has 30% accumulation allowance for their RTS – Cumulative safety edit. A member initially fills a 30-day supply on Jan. 1, 2025. With a 30% accumulation allowance, their earliest fill will be payable nine days prior to running out of the medication, on Jan. 22, 2025. The member's third fill will consider the on-hand quantity and adjust their future fill date so that the member's on-hand quantity will not exceed 30% of the submitted days' supply on the claim. Therefore, the next refill date will be payable 30 days later on or after Feb. 21, 2025. In this example, the member would not be allowed to accumulate more than 30% of the days' supply on the claim within a 180-day time frame, which would be nine days for a 30-day supply. If the member's claims were for a 90-day supply, the member could accumulate up to a 27-day supply within a 180-day time frame. To help ensure our members obtain their needed medications, the dispensing pharmacist should review the Refill Too Soon edit and, if the prescription is deemed appropriate, call Prime's Pharmacy Help Desk to request an override for the rejection. Of note, additional utilization management edits such as prior authorization and/or quantity limits may still apply.

Medicare Split-Fill program

In 2025, Prime expanded our Medicare Soft Split-Fill program, which is an educational program intended to reduce waste and help avoid costs of medication that may go unused. The program relies on point-of-sale pharmacy messaging and formulary publication indicators to identify drugs that have a high incidence of intolerance and side effects. The point-of-sale messaging states: "TRY A PARTIAL DAY SUPPLY FOR COPAY MGMT IF NEW OR INTOLERANT OR CHANGE OF THERAPY."

The program leverages Medicare daily cost sharing. Soft Split-Fill informs members that they can fill a partial days' supply through conversations initiated by the pharmacist. Drugs added to Prime's Split Fill list are carefully evaluated based on clinical and cost criteria which also includes a thorough review of packaging and/or storage restrictions. Drugs are not added to Split Fill unless our clinicians determine that the packaging can be safely and consistently split to support the partial fill process and durations recommended for each individual drug.

If you see the point-of-sale messaging, please consult with the patient about trying a partial fill for copay management. They may see cost savings if intolerant or changing therapy due to side effects. Thank you for your help assisting our members; we appreciate the work you do.

Medicare E1 eligibility query

An E1 eligibility query is a real-time transaction submitted by a Pharmacy to RelayHealth, the transaction facilitator contracted by CMS to house Medicare eligibility information and respond to transaction requests. An E1 helps determine a member's Medicare Part D coverage and payer order if the member has insurance through more than one benefit plan.

Pharmacies generally submit E1 queries when members do not have their Medicare Part D identification card. Pharmacies should not submit an E1 query for pharmaceutical manufacturer copay assistance coupon programs.

You can visit **Medifacd.McKesson.com/E1/** for additional information on E1 transactions.

CMS standardized pharmacy notice

CMS requires all Medicare Part D benefit plan sponsors to use a single uniform exceptions and appeals process, with respect to the determination of prescription drug coverage for a member under the plan. Medicare Part D claims will be rejected when a claim cannot be covered under the Medicare Part D benefit plan at the point of sale.

Pharmacy messaging
Pharmacy claims will be rejected with the following POS reject code:

- NCPDP Reject Code 569

Pharmacies are required to provide members with the CMS Notice of Medicare Prescription Drug Coverage and Your Rights when they receive NCPDP Reject Code 569. The CMS Notice of Medicare Prescription Drug Coverage and Your Rights form is posted on Prime's website at **PrimeTherapeutics.com/ Additional-Resources**.

Home infusion Pharmacies receiving the NCPDP Reject Code 569 must distribute the CMS notice to the member either electronically, by fax, in person or by first-class mail within 72 hours of receiving the claim rejection.

Long-term care (LTC) Pharmacies receiving the NCPDP Reject Code 569 must contact the prescribing provider or LTC facility to resolve the rejected claim to ensure the member receives their needed medication or an appropriate substitute. If the Pharmacy must distribute the CMS notice, they must fax or deliver the notice to the member, the member's representative, the prescribing provider or the LTC facility within 72 hours of receiving the claim rejection.

A copy of the CMS Notice of Medicare Prescription Drug Coverage and Your Rights is included on page 9.

National Plan and Provider Enumeration System updates

To ensure pharmacy directory accuracy, the National Plan/Provider Enumeration System (NPPES) now allows Pharmacies to certify their National Provider Identifier (NPI) data. Please submit any changes to your Pharmacy's demographic information, including Pharmacy name, address, specialty and telephone number as soon as you are aware of these changes.

Enrollee name: _____(optional)

Drug and prescription number: _____(optional)

Medicare Drug Coverage and Your Rights

You have the right to ask for a coverage determination from your Medicare drug plan to provide or pay for a drug you think should be covered, provided or continued. You also have the right to ask for a special type of coverage determination called an "exception" if you:

- Need a drug that's not on your plan's list of covered drugs
- Believe a coverage rule (like prior authorization or a quantity limit) shouldn't apply to you for medical reasons
- Need to take a nonpreferred drug and you want the plan to cover the drug at a preferred drug price

How to ask for a coverage determination
To ask for a coverage determination, you or your prescriber can call your Medicare drug plan's toll-free phone number on the back of your plan membership card, or you can go to your plan's website. You can ask for an expedited (24-hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision.

Be ready to tell your Medicare drug plan:
- The name of the prescription drug, including dose and strength (if known)
- The name of the pharmacy that tried to fill the prescription
- The date you tried to fill the prescription
- If you ask for an exception, your prescriber will need to explain why you need the off-formulary or nonpreferred drug, or why a coverage rule shouldn't apply to you

Your Medicare drug plan will send you a written decision. If coverage isn't approved and you disagree with this decision, you have the right to appeal. The plan's notice will explain why coverage was denied and how to ask for an appeal.

Get help and more information
Look at your plan materials or call **1.800.MEDICARE (1.800.633.4227)** for more information about how to ask for a coverage determination. TTY users can call **1.877.486.2048**. For help contacting your plan, call **1.800.MEDICARE.**

To get this form in an accessible format (like large print, Braille or audio) contact your Medicare drug plan. You also have the right to file a complaint if you feel you've been discriminated against. **Visit Medicare.gov/About-Us/Accessibility-Nondiscrimination-Notice**, or call **1.800.MEDICARE (1.800.633.4227)** for more information. TTY users can call **1.877.486.2048**.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. This information collection is used to provide notice to enrollees about how to contact their Part D plan to request a coverage determination. The time required to complete this information collection is estimated to average 1 minute per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is required under § 423.562(a)(3) and an associated regulatory provision at §423.128(b)(7)(iii). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS -10147 OMB Approval No. 0938-0975 (Expires: 12/31/2027)

Florida news

Florida Blue utilization management program

We will post to **PrimeTherapeutics.com/Resources** any utilization management (UM) program updates for the upcoming quarter, when available.

Prime news

Biosimilars for Stelara

Stelara Biosimilars have launched, and as a result, the statuses of formularies may have changed for Stelara. Not all formularies will continue to cover Stelara beginning July 1. Most formularies are covering the following Stelara biosims on July 1: Selarsdi, Steqeyma, Yesintek

Pharmacy licensure

Pharmacies with independent contracts must provide Prime with the following on an annual basis: Certificate of Insurance with proof of general and professional liability insurance

Please visit **PrimeTherapeutics.com/Pharmacy-Credentialing** to update our records.

Choose **Renewal of Pharmacy Certificate of Insurance** from the options and follow the instructions to upload and submit a PDF of your current or renewed Certificate of Insurance.

Annual attestation requirement

The annual FWA attestation form is part of your Pharmacy NCPDP profile. Please complete the form via the NCPDP website. For your convenience, you can go to **PrimeTherapeutics.com/Compliance-Training1** to find instructions for completing the NCPDP form. Pharmacies are also required to complete the offshoring attestation when applicable. Failure to attest to the annual general compliance, FWA training and offshoring may result in termination of participation in one or more networks or termination of the agreement.

Provider Manual update

You can visit **PrimeTherapeutics.com/Provider-Manual** to find a new version of Prime's Provider Manual with an effective date of July 1, 2025, available for review. Please continue to use the January 2025 Provider Manual until July 1, 2025.

MAC list updates

If a Pharmacy would like access to Prime's Maximum Allowable Cost (MAC) lists, weekly MAC changes, the sources used to determine MAC pricing and the appeals process, please refer to Prime's website for registration instructions. After network participation is verified, the Pharmacy will receive a secure username and password via email.

How to reach Prime

As a service to Pharmacies, Prime publishes the *Prime Perspective* to provide important information regarding claims processing. Prime values your opinion and participation in our network. If you have comments or questions, please contact us:

- Phone: Prime's Pharmacy Contact Center **800.821.4795** (24 hours a day, 7 days a week)
- Email: **ProviderRelations@PrimeTherapeutics.com**
- Mail: 2900 Ames Crossing Road, Suite 200, Eagan, MN 55121

Where do I find formularies?

For commercial formularies, access either the Blue Cross and Blue Shield plan website or **PrimeTherapeutics.com/Commercial-Formularies**.

For Medicare Part D formularies, access **PrimeTherapeutics.com/Formularies-Med-D**.

Keep your pharmacy information current

Prime uses the NCPDP database to obtain key pharmacy demographic information. To update your pharmacy information, go to **NCPDP.org** and click on **Pharmacy Login** at the top right.

Report compliance, privacy, or fraud, waste and abuse concerns

Prime offers the following hotlines to report compliance, privacy, and fraud, waste and abuse (FWA) concerns:

Compliance

Report suspected compliance concerns:

- Phone: **612.777.5523**
- Email: **Compliance@PrimeTherapeutics.com**

Privacy

Report privacy concerns or potential protected health information (PHI) disclosures to Prime:

- Privacy Hotline: **888.849.7840**
- Email: **Privacy@PrimeTherapeutics.com**

Fraud, waste and abuse

If you suspect FWA by a covered person, prescribing provider, Pharmacy or anyone else, notify Prime:

- Phone: **800.731.3269**
- Email: **FraudTipHotline@PrimeTherapeutics.com**

Anonymous reporting

Report a compliance concern or suspected FWA anonymously:

- Phone: **800.474.8651**
- Email: **Reports@Lighthouse-Services.com**
- Third party vendor's website: **Lighthouse-Services.com/Prime**