Prime Perspective

Prime Perspective provides information and updates about Prime services

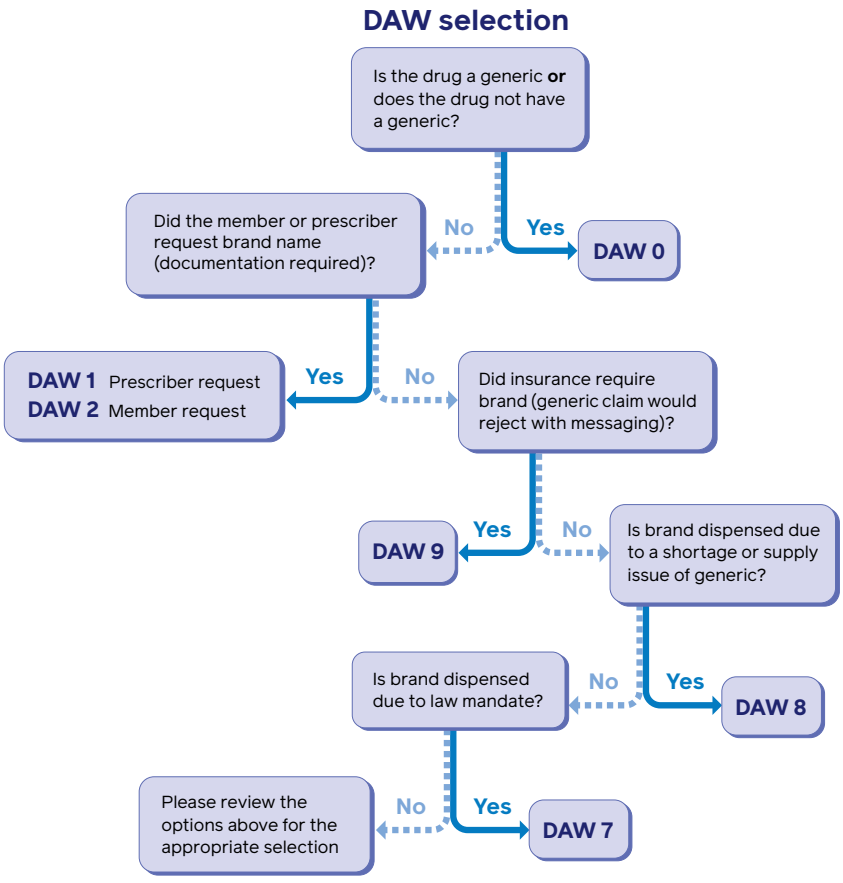
December 2024: Issue 92

Inside

Fraud, waste and abuse (FWA) updates

Dispense as Written (DAW) code selection

Prime Therapeutics Dispense as Written (DAW) code selection (Prime) continues to see inappropriate Dispense as Written (DAW) code selection. On the following page, we have provided a guide to help you select the appropriate DAW code. Choosing the correct DAW code helps control costs and keeps your Pharmacy compliant with the standards set by the National Council for Prescription Drug Programs (NCPDP). Please refer to this decision tree each time you apply a DAW code to a claim.



These are DAW codes that are uncommon for use and will reject at point of sale. Pharmacies should review the table above to identify the appropriate code to use.

DAW 3 Pharmicists selected product (do not use if prescriber authorized multiple products based on coverage)
DAW 4 Generic not in stock (not due to any other reasons on this chart)
DAW 5 Brand name dispensed as generic (note that reimbursement is for generic)
DAW 6 Other (not used at Prime)

If Pharmacy is not able to identify the appropriate code to use, please contact the Prime help desk for support.

GLP-1 DUR rejection

Prime has identified a large volume of pharmacy claims surrounding GLP-1 (glucagon-like peptide-1) agonists for type 2 diabetes and weight loss. Many of these claims, although paid, have been flagged as early fills or as being related to drug utilization review (DUR) duplicate therapy. If you are a pharmacy provider who is noting claims surrounding GLP-1 early fills or duplications, please review the following guidance.

- Early fills:
  - The Pharmacy has a responsibility to monitor early filling of prescriptions. Early or excessive fills can lead to waste and safety concerns.
- Duplicate therapies:
  - The Pharmacy is expected to review a member's profile to evaluate potential drug-to-drug interactions or drug-to-disease contraindications. In this DUR review, the Pharmacy should discourage duplicate therapy. In the case of a drug shortage or therapy switch, best practice would be for the Pharmacy to deactivate replacement prescriptions that are no longer the member's current therapy.
  - GLP-1 medications should never be used concomitantly. Duplication could pose a risk of potentially serious side effects.
- In specific cases where professional judgement is expressed and an override on the claim has been made, documentation of clinical justification is required on the hard copy.

DUR Reject Code 76 (Plan Limitations Exceeded)

Prime has identified a large volume of pharmacy claims denials related to DUR. If you are a pharmacy provider whose claim was denied with a Reject Code 76 for opioid prescriptions, please review the following guidance.

A claim for an opioid drug may be denied with Reject Code 76. When denied, you may see the supplemental message: "The Centers for Disease Control and Prevention (CDC) recommend that clinicians assess benefits and risks when increasing Opioid Morphine Milligram Equivalent (MME) dosage to >/=90 MME/day. Consider co-prescribing naloxone when a patient is considered to be at risk of an overdose." Please submit appropriate DUR override codes if dosage is deemed medically necessary and document clinical justification on hard copy.

The MME alert will trigger in instances where the MME of a single claim or the cumulative MME across multiple claims is >90 MME/day and <500 MME/day. When the alert is triggered, claims will deny with Rejection Code 76. To override MME alerts, providers should submit only "HC" as the reason for service code and populate other fields with appropriate codes.

- Reason for service code:
  - HC: High cumulative dose
- Professional service codes:
  - CC: Coordination of care
  - DE: Dosing evaluation/determination
  - DP: Dosage evaluated
- Result of service codes:
  - 4B: Dispensed, palliative care
  - 4C: Dispensed, hospice
  - 4D: Dispensed, cancer treatment
  - 4E: Dispensed, chronic pain
  - 4F: Dispensed, surgery/trauma
  - 4G: Dispensed, surgery/trauma
  - 4H: Dispensed, hospital admission/discharge
  - 4J: Dispensed, patient is not opioid naïve

Return to stock: unclaimed prescriptions

Pharmacies are required to reverse any claim for a prescription drug service that is not delivered to or received by the covered person within 14 days of submission, unless a shorter time period is required by law or individual company policy. Claims not reversed within 14 days that are not received by the covered person are subject to audit and investigation. This may result in collections through the retrospective pharmacy audit process or investigation. This includes claims that were billed in a previous benefit year that may have a different copay once the new benefit year begins.

New year and insurance updates

With the start of a new calendar year, many members will have benefit changes or updates. Pharmacies should ensure they are asking members for new insurance cards and verify that they have the correct processing information on file. Additionally, if a member is new to filling at a particular Pharmacy, the Pharmacy should be aware of and abide by any DUR messages alerting to an early refill based on claims history at a previous Pharmacy. Claims that are refilled early despite having this DUR alert will be subject to the pharmacy audit process and/or investigation, and any findings may be subject to post-audit claim adjustments by Prime.

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

IRA impacts to Medicare Part D for 2025

The Inflation Reduction Act (IRA) included several provisions that will impact Medicare Part D beginning Jan. 1, 2025. These are the most significant changes to the Medicare Part D program since its inception.

Major changes will include elimination of the coverage gap, an annual out-of-pocket cost cap of $2,000 for beneficiaries and application of a new manufacturer discount program during claim adjudication. These changes will result in lower overall costs for members at the point of sale.

A major component of the IRA is the Medicare Prescription Payment Plan (M3P). Members can choose to participate in this optional program, and it is intended to spread out their out-of-pocket costs more evenly throughout the plan year. Members most likely to benefit from the program are those who have high out-of-pocket costs early in the plan year.

Once a member has elected to join the program, they will pay no out-of-pocket costs at the point of sale and will be billed in monthly payments by their health plan.

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:

- Eligible Medicare Part D members receive the appropriate Likely to Benefit notice provided by the Pharmacy
- Proper training is 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 M3P.

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 their 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.

The enrollee may choose to take time to consider opting into the program and may leave the Pharmacy without the prescription that triggered the notification. In these cases, 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.

Should a Part D enrollee have other unpaid claims at the same Pharmacy for covered Part D drugs from prior dates of service, in addition to the prescription that may have triggered the Likely to Benefit notification, the enrollee may also request that those claims be reversed and reprocessed, to be included in M3P.

When a Medicare Part D member is participating in M3P 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 method of COB processing. An Other Coverage Code of 08 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 that will be released in Q4 2024.

When a supplemental payer is billed after the Part D claim and before the M3P claim, and the supplemental claim returns a higher out-of-pocket cost than the Part D claim, M3P will pay up to the Medicare Part D out-of-pocket cost. 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 as a product defined as covered by the Medicare Part D core benefit. These claims cannot be billed to M3P.

Pharmacies must be prepared to begin distributing the Likely to Benefit notice and processing M3P claims on Jan. 1, 2025.

Medicare Part B coverage expanded for medications used to prevent HIV

The Centers for Medicare & Medicaid Services (CMS) expanded Part B coverage for drugs approved to prevent human immunodeficiency virus (HIV) with the finalization of a new national coverage determination (NCD) policy, "*Preexposure 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 PrEP (not for use as treatment of HIV); short descriptor: HIV PrEP, ftc/tdf 200/300 mg
- J0751 – Emtricitabine 200 mg and tenofovir alafenamide 25 mg (Descovy); oral, FDA-approved prescription, only for use as HIV PrEP (not for use as treatment of HIV); short descriptor: HIV PrEP, ftc/taf 200/25 mg
- J0739 – Cabotegravir, 1 mg (Apretude); injection, FDA-approved prescription, only for use as HIV PrEP (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 plan (MAPD), 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 Contact Center at **800.821.4795**.

Pulmonary arterial hypertension

Pulmonary arterial hypertension (PAH) is often treated with sildenafil. Both Cialis and Adcirca are brand names for sildenafil. Adcirca 20 mg has been approved by the FDA for PAH, whereas Cialis 20 mg does not have this approved indication.

As referenced in Section 20.1 of Chapter 6 of the Medicare Prescription Drug Benefit Manual, Medicare Part D does not cover drugs or their medical uses, which are excluded from coverage or otherwise restricted per section 1860D-2(e)(2)(A) of the Social Security Act. Those drugs include those used for the treatment of sexual or erectile dysfunction, unless such drugs were used to treat a condition other than sexual or erectile dysfunction for which the drugs have been approved by the FDA.

Pharmacy messaging
Claims for the generic sildenafil 20 mg will reject with the below messaging.

- NCPDP Reject Code A5: "NOT COVERED UNDER PART D LAW"
- Secondary message: "CONFIRM DX, IF PAH USE GENERIC FOR ADCIRCA (TADALAFIL 20mg), PA/QL REQUIRED"

To ensure members have access to their needed prescription, please verify the indication for use. If the intended use is PAH, please process claim with generic Adcirca 20 mg. The product will still require a prior authorization.

Medical supplies associated with the delivery of insulin

Effective Jan. 1, 2025, Prime will require verification of insulin therapy when dispensing medical supplies associated with the delivery of insulin (e.g., 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.

Pharmacy messaging

- 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 members purchase needed medical supplies when not associated with the delivery of insulin.

End-stage renal disease: 2025 updates on phosphate binders

Beginning Jan. 1, 2025, Medicare will begin reimbursing dialysis facilities for oral-only phosphate binders for end-stage renal disease (ESRD) patients under its Part B bundled payment system. Consequently, Part D will no longer be eligible to pay for these drugs for ESRD patients for any indication that is related to ESRD.

Medicare members with ESRD who have been obtaining oral-only phosphate binders via Part D will need to obtain these medications from their dialysis facility.

Pharmacy messaging
For Medicare members with ESRD, claims will reject with NCPDP Reject Code A4 with messaging: "ESRD DRUG COVERED BY ESRD FACILITY. IF NOT TREATING ESRD COND - PA REQUIRED FOR PART D. Q&A CALL **800.821.4795**".

For Medicare members without ESRD, claims will reject with NCPDP Reject Code MR: "Drug Not on Formulary". Auryxia claims will also reject for appropriate diagnosis in transition verification (ADTV).

Medicare billing code	Generic name	Associated brand name
J0601 (tablet) J0602 (powder)	sevelamer carbonate	Renvela
J0603	sevelamer hydrochloride	Renagel
J0605	sucroferric oxyhydroxide	Velphoro
J0607 (tablet) J0608 (powder)	lanthanum carbonate	Fosrenol
J0609	ferric citrate	Auryxia
J0615	calcium acetate	PhosLo

To ensure members have access to their needed prescription, direct members to obtain their medication from their dialysis facility.

DUR therapeutic duplication misuse

Prime has observed a high volume of concurrent use of multiple GLP-1s and use of GLP-1s with DPP-4s (dipeptidyl peptidase-4) among 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
- SGLT2 (sodium-glucose cotransporter-2) + SGLT2

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 SGLT2 + SGLT2. When triggered, this point-of-sale safety edit will result in the below messaging.

Pharmacy messaging

- NCPDP Reject Code 88: "XXXXXX"
- 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 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 safety edit

Prime is expanding 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: "XXXXXX"
- 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, the member's earliest fill will be payable Jan. 22, nine days prior to running out of the medication. 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 day 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 day 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 90-day supplies, 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 Contact Center at **800.821.4795** to request an override for the rejection. Note: Additional utilization management edits such as prior authorization and/or quantity limits may still apply.

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 find 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 to Covered Persons has been included on Page 9 of this publication.

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.

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.

Enrollee's Name:_____(Optional)

Drug and Prescription Number:_____(Optional)

Medicare Prescription Drug Coverage and Your Rights

Your Medicare rights

You **have the right to request a coverage determination** from your Medicare drug plan if you disagree with information provided by the pharmacy. You also **have the right to request a special type of coverage determination called an "exception"** if you believe:

- you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- you need to take a non-preferred drug and you want the plan to cover the drug at a preferred drug price.

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request 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:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you with a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the plan's decision.

Refer to your plan materials or call 1-800-Medicare for more information.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

New plan announcement

Blue Cross and Blue Shield of Kansas Blue MedicareRx PDP

Effective Jan. 1, 2025, Prime Therapeutics (Prime) will begin processing Medicare Part D claims for covered persons of Blue Cross and Blue Shield of Kansas Blue MedicareRx PDP

Processing requirements

To ensure uninterrupted service to participating Pharmacies and covered persons of the of Blue Cross and Blue Shield of Kansas Blue MedicareRx PDP, please use the following information to set up your system prior to Jan. 1, 2025.

BIN: 610455

PCN: . . . . . KSPDP

RXGRP: S5726

- Covered person ID number
- Date of birth
- Gender
- Rx group number
- U&C
- Days' supply
- Pharmacy NPI
- Active/valid prescriber ID NPI
- Date prescription written
- Prescription origin code
- Pharmacy service type
- Patient residence

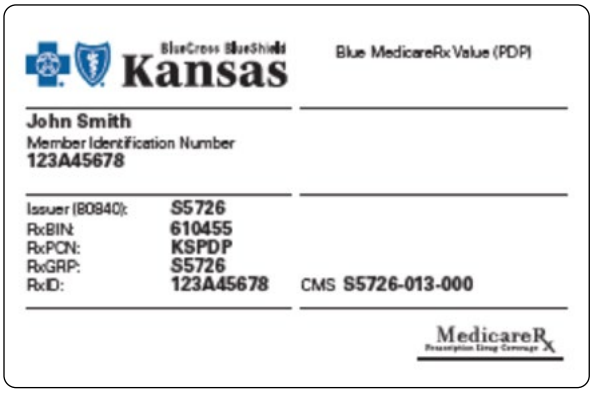
Outstanding claim reversals and processing

- To prepare for this transition, participating Pharmacies should complete all claims processing and reversals by close of business Dec. 31, 2024.
- For assistance with claims that have a date of fill prior to Jan. 1, 2025, please submit claims to BIN: 020115 PCN: IS or call **833.377.4266**.

For more information

- Beginning Jan. 1, 2025, if you have questions regarding claims processing, please contact Prime's Contact Center at **866.421.5172**.
- Prime's Medicare Part D payer specification sheet is available at: PrimeTherapeutics.com> Providers and Physicians> Payer Sheets> Medicare Part D D.0 Payer Sheet.

Featured below are examples of the most common ID card used:



Medicare processing update

Blue Cross and Blue Shield of Nebraska Medicare Advantage new covered person ID

BCBSNE Medicare Advantage Core (HMO), Access (PPO), Connect (PPO), Secure (PPO), and Employer Group PPO Rx CY

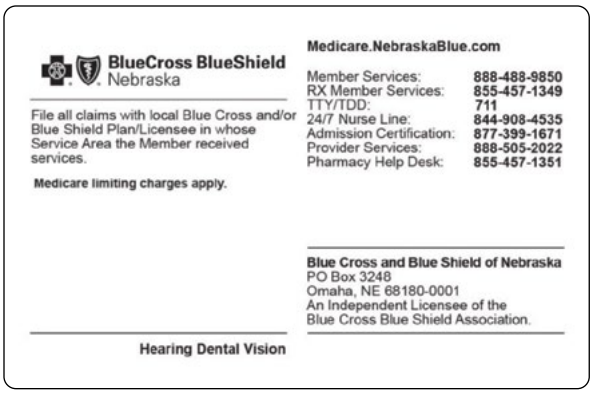
Effective Jan. 1, 2025, Blue Cross and Blue Shield of Nebraska (BCBSNE) covered persons will have new member ID numbers. Blue Cross and Blue Shield of Nebraska is issuing new ID cards to Medicare covered persons in mid-December. These cards will have a new member ID, which is effective 1/1/2025. Any claims using a member ID from 2024 will be denied at point of sale. Covered persons have been instructed to present their new ID card when filling a prescription. Pharmacies experiencing issues processing claims using the new ID cards are encouraged to contact Prime's Contact Center at **855.457.1351**.

Covered person ID numbers will change from a 9-character alphanumeric ID (N12345678) to a 12-digit alphanumeric ID (Y2M123456789). Pharmacies will need to disregard the three-character alphanumeric prefix and just submit the remaining 9-digit ID number.

All claims for covered persons of BCBNE Medicare Advantage Core (HMO), Access (PPO), Connect (PPO), Secure (PPO) and Employer Group PPO Rx CY should be submitting claims using the information in the table on this page.

Plan sponsor	Plan name	BIN	PCN
BCBSNE	Medicare Advantage Core (HMO)	610455	ENEH3170
BCBSNE	Medicare Advantage Access (PPO) Medicare Advantage Connect (PPO) Medicare Advantage Secure (PPO)	610455	ENEH8181
BCBSNE	Employer Group PPO Rx CY (PPO)	610455	ENEH8181G

Featured below are examples of the most common ID card:



New plan announcement

Solis Health Plans

Effective Jan. 1, 2025, Prime Therapeutics (Prime) will begin processing Medicare Part D and B claims for covered members of Solis Health Plans.

Processing requirements

To ensure uninterrupted service to participating Pharmacies and covered members of Solis Health Plans, please use the following information to set up your system prior to Jan. 1, 2025.

BIN: 610455

PCN: . . . . . SOMAPD

RXGRP: H0982

- Covered member ID number
- Date of birth
- Gender
- Rx group number
- U&C
- Days' supply
- Pharmacy NPI
- Active/valid prescriber ID NPI
- Date prescription written
- Prescription origin code
- Pharmacy service type
- Patient residence

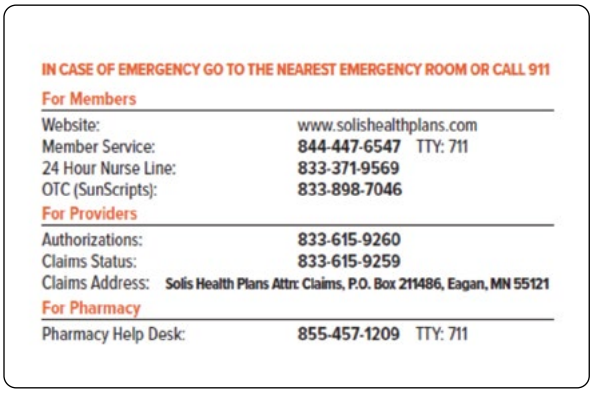
Outstanding claim reversals and processing

- To prepare for this transition, participating Pharmacies should complete all claims processing and reversals by close of business Dec. 31, 2024.
- For assistance with claims that have a date of fill prior to Jan. 1, 2025, please contact Navitus at **866.333.2757**.

For more information

- Beginning Jan. 1, 2025, if you have questions regarding claims processing, please contact Prime's Contact Center at **855.457.1209**.
- Prime's Medicare Part D payer specification sheet is available at: PrimeTherapeutics.com> Providers and Physicians> Payer Sheets> Medicare Part D D.0 Payer Sheet.

Featured below are examples of the most common ID card used:



Prime news

Vaccine coverage

As a reminder, the following plan sponsors use the commercial vaccine network contracted by Prime:

- BCBS of Alabama
- BCBS of Illinois
- BCBS of Kansas
- BCBS of Minnesota
- BCBS of Montana
- BCBS of Nebraska
- BCBS of New Mexico
- BCBS of North Carolina
- BCBS of North Dakota
- BCBS of Oklahoma
- BCBS of Rhode Island
- BCBS of Texas
- BCBS of Wyoming
- Boeing
- BridgeSpan Health Idaho
- BridgeSpan Health Oregon
- BridgeSpan Health Utah
- BridgeSpan Health Washington
- Capital Health Plan
- Florida Blue
- Horizon BCBS of New Jersey
- Regence BlueShield of Idaho
- Regence BlueCross BlueShield of Oregon
- Regence BlueCross BlueShield of Utah
- Regence BlueShield
- Truli for Health

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 Jan. 1, 2025, available for review. Please continue to use the July 2024 Provider Manual until Jan. 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 Therapeutics

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:

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

Where do I find formularies?

For commercial formularies, access either the Blue Cross 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**