



PRIME THERAPEUTICS
**PROVIDER
MANUAL**
FOR PHARMACY PROVIDERS



Effective January 1, 2020

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INTRODUCTION TO PRIME THERAPEUTICS

INTRODUCTION

Prime Therapeutics LLC (Prime) manages pharmacy benefits for Benefit Sponsors. Prime contracts and manages networks of Pharmacies on behalf of Benefit Sponsors (Prime's Networks or Prime's Medicare Network).

Prime's services include among other services:

- Pharmacy Network management
- Drug Formulary management
- Pharmacy communication
- Drug utilization review (DUR)
- Clinical programs
- Prescribing Provider outreach
- Claims processing

Prime manages Pharmacy Networks to provide Prescription Drug Services for our Benefit Sponsors through our online claims processing system. This system gives Pharmacies real-time access to:

- Covered Person eligibility
- Drug coverage information
- Drugs requiring prior authorization
- DUR information

Prime is committed to doing business with integrity 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). Click here to access [Prime's code of conduct](#).

PROVIDER MANUAL

The purpose of this Provider Manual ("Manual") is to explain Prime's administrative and compliance policies and procedures for participation in Prime's Networks. 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](https://www.PrimeTherapeutics.com).

Prime posts relevant instructions, notices, information and supplements or changes to this Manual on the [Prime Website](#). Visit [Prime's Website](#) 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.

Failure to comply with Prime's contractual terms and conditions, including but not limited to those described in the Manual, may result in placement on a corrective action plan, full or partial financial recoupment, network termination or other remediation actions, as determined by Prime and permitted by applicable law.

SECTION 1: PRIME CONTACT INFORMATION

PRIME MAILING ADDRESS

If you would like additional information, contact Prime at:

Prime Therapeutics
P.O. Box 64812
St. Paul, MN 55164-9403

PRIME'S CONTACT CENTER

800.821.4795

Prime's Contact Center has dedicated staff to assist Pharmacies. They can help 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 **Prime's Website** (www.PrimeTherapeutics.com) for the following information:

- **Payer sheet**
- **Medicare Prescription Drug Coverage and Your Rights**
- **Formularies – Commercial**
- **Formularies – Medicare Part D**
- **Prime Perspective newsletters**
- **Compliance/Fraud, waste and abuse**
- **Plan announcements**
- **Network request form**
- **Common billing errors**
- **Minimum Performance and Service Criteria for Medicare Part D Programs**
- **Minimum Performance Criteria for LTC**
- **Medicare Part B vs. Part D coverage issues**
- **Pharmacy Audit Appeal form**
- **Prime Audit Advisor/Fax series**
- **Audit Guidelines**
- **FAQ: Claim Adjustments**
- **Long-Term Care and Home Infusion General Dispensing Requirements**
- **Home Infusion (HI) validation**
- **Long-term care (LTC) validation**
- **Medicaid programs**
- **Vaccine program**
- **Check Inquiry form**
- **Maximum Allowable Cost (MAC)**

SECTION 2: COMPLIANCE

REPORT COMPLIANCE, PRIVACY, OR FRAUD, WASTE AND ABUSE 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:

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

Fraud, Waste and Abuse

If you suspect Fraud, Waste or Abuse (FWA) by a Covered Person, Prescribing Provider, Pharmacy or anyone else, notify Prime:

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

If you suspect FWA involving the Federal Employees Plan by a Covered Person, Prescribing Provider, Pharmacy or anyone else, notify Prime:

- Phone: **844.765.9990**
- Email: FEPreportfraud@PrimeTherapeutics.com

Anonymous Reporting:

Report a compliance concern or suspected Fraud, Waste or Abuse anonymously by contacting Prime's 24-hour anonymous compliance hotline:

- By phone: **800.474.8651**
- By email: reports@lighthouse-services.com
- By third party vendor's website: www.lighthouse-services.com/prime

Please contact Prime's compliance department with any concerns, including, but not limited to:

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

COMPLIANCE PROGRAM

Prime requires all Pharmacies to adopt appropriate compliance programs, including, but not limited to:

- Codes of conduct
- FWA programs
- Conflict of interest policies and procedures

Pharmacies must develop policies and procedures in compliance with all applicable rules and regulations, including but not limited to Medicare Programs.

Pharmacies should have someone who is responsible for establishing and documenting a plan to meet Medicare Program requirements. 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.

FRAUD, WASTE AND ABUSE (FWA)

Annual Attestation Requirement

The annual FWA attestation form is now part of your pharmacy NCPDP profile. Please complete the form via the NCPDP website. For your convenience, training and instructions for completing the NCPDP form are on [Prime's Website](#). Failure to attest to the annual general compliance and FWA training may result in termination from Prime's Networks.

Medicare Part D FWA and General Compliance Pharmacy Training and Certification

CMS requires any staff providing Medicare Part D services to receive qualified Fraud, Waste and Abuse (FWA) and General Compliance training upon hire and annually thereafter. Every year, on behalf of the Part D Plan Sponsors it serves, Prime is required to track completion of this training by all Pharmacies in Prime's Networks. Pharmacies can submit a single attestation to NCPDP (as part of your pharmacy profile), which will be submitted to Prime. The FWA and General Compliance training needs to be CMS certified to be compliant with the training requirement. When a pharmacy indicates that offshore services are provided in their FWA and General Compliance training attestations, the Pharmacy must complete an additional offshore questionnaire regarding the offshore services vendor.

Reporting of Suspicious Activity

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

Pharmacies must exercise due diligence to ensure prescriptions are valid. For example, if the Pharmacy receives a prescription order that appears potentially altered or forged, contact the Prescribing Provider to:

- Validate the prescription
- Document the prescription order with date and time
- Include the representative name from the Prescribing Provider's office

At all times, remain mindful of FWA and report suspicious activity to Prime promptly.

Please contact Prime's FWA Department as set forth in the Compliance section of this Manual with any FWA concerns. Examples of potential FWA include but are not limited to:

- **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 fakes illness to obtain drugs for illegal resale.
- **Prescribing Provider shopping**—A Covered Person consults a number of Prescribing Providers to inappropriately obtain multiple prescriptions. Pharmacist shall make every reasonable effort to ensure that any prescription drug order, regardless of the means of transmission, has been issued for a legitimate medical purpose by a Prescribing Provider in the course of the valid and lawful practice of medicine. A pharmacist shall not dispense a prescription drug if the pharmacist knows or should have known that the order for such drug was issued without a valid pre-existing patient-Prescribing Provider relationship or without a valid prescription drug order.

SECTION 2: COMPLIANCE (CONTINUED)

Patient/Prescribing Provider Relationship Definition:

There are three (3) ways a patient-Prescribing Provider relationship can be established: 1. there is a pre-existing Prescribing Provider-patient relationship; 2. the Prescribing Provider communicated with the patient as part of a call coverage agreement with the patient's established Prescribing Provider; or 3. The Prescribing Provider communicates with the patient using: a. real-time audiovisual interaction, such as through video calls; b. real-time audio (telephone), along with having access to clinically relevant information, such as videos/images, medical records, and test results; or c. any other audiovisual telecommunication technology that allows the Prescribing Provider to meet the standard of care for an in-person setting.

- **Script mills**—A Prescribing Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for Covered Persons who are not the Prescribing Provider's patients. These prescriptions are sometimes written for drugs found on a schedule of controlled substances for illegal sale. These prescriptions may also result in improper payments to the Prescribing Provider.
- **Theft of Prescribing Provider's Drug Enforcement Administration (DEA) number or prescription pad**—These are stolen from Prescribing Providers 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" (for example, a pharmacist visits a long-term care facility and bills for numerous pharmaceutical prescriptions without providing prescriptions to Covered Persons)
 - › Inappropriate use of product selection 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)
 - › Drug diversion
 - › Phishing to identify a drug that is covered (i.e., a Pharmacy submits a claim for one drug, received a reject or reverses the claim and resubmits for a new drug within a short period of time)
 - › Prescription splitting to bypass Point of Sale (POS) messaging requiring a prior authorization
 - › Billing a greater vial size than what is necessary to supply the ordered dose
 - › Waiving Copays—A Pharmacy does not collect the copay due from the Covered Person, when required by the Agreement
 - › Misrepresenting or falsifying information to obtain a paid claim
- **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 POS, the Covered Person is charged a higher amount.
- **Prescription forging or altering**—Existing prescriptions are altered by a Covered Person without the Prescribing Provider's permission to increase the quantity or number of refills.

SECTION 2: COMPLIANCE (CONTINUED)

- **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.
- **Illegal remuneration schemes (kickbacks)**—A Pharmacy is offered, solicits, or receives unlawful payment which results in an incentive or reward for switching Covered Persons to different drugs, influencing Prescribing Providers 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 the Covered Person can reach catastrophic coverage before being 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.
- **Inappropriate application of therapeutic interchange protocols**—A Pharmacy dispensing a different covered medication than prescribed without obtaining and documenting the Prescribing Provider's consent prior to dispensing and without informing the Covered Person of the substitution.

SECTION 3: CLAIMS PROCESSING

GENERAL INFORMATION

Online Claims Submission

The 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.

The Pharmacy must provide a Covered Person adequate information as to where the prescription service can be electronically submitted in situations where pharmacist judgment or applicable law permits the denial of Prescription Drug Service.

Online Availability

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

Claim Formats

- POS claims must be submitted in the current NCPDP format or current industry 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](https://www.ncdp.org).

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

The Pharmacy must review all POS messaging for processing information and Payer sheets located on [Prime's Website](#) for software set up.

In order for Prime to assist Pharmacies with claims adjudication, please email your unique processing codes, condor codes, and/or input codes:

PharmacyOps@PrimeTherapeutics.com.

Medicare Reference Materials

These documents are available on [Prime's Website](#):

- [Medicare Prescription Drug Coverage and Your Rights Standardized Pharmacy Notice Instruction](#)
- [Medicare Prescription Drug Coverage and Your Rights](#)
- [Medicare Part B vs. D Coverage Issues](#)
- [Minimum Performance and Service Criteria for Medicare Part D](#)
- [Minimum Performance and Service Criteria for LTC](#)

ELIGIBILITY

Covered Person Identification Card

The Pharmacy shall require a Covered Person to present a Covered Person Identification 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 Pharmacy is unsure of eligibility, the Pharmacy must use reasonable steps to confirm the identity of the Covered Person through validation of a government issued identification card or contact Prime's Contact Center at **800.821.4795** to obtain accurate Covered Person information prior to dispensing a product or processing a claim.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

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 or as allowed by applicable law). If drug service is denied based on professional judgment or applicable law, the Pharmacy or pharmacist shall provide the Covered Person adequate information as to where the prescription service can be provided.
- Be asked to pay more than is due under the terms of the Agreement.
- Be asked to pay cash and submit a paper claim, unless otherwise allowed by applicable law.

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 Prescription Drug Service.

In the event a claim is processed using incorrect eligibility, upon notice, Prime may adjust the claim to reflect correct eligibility and corresponding Benefit Plan coverage. If this occurs, Pharmacy shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Covered Person, or persons acting on behalf of the Covered Person.

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

Schedule II Prescription Dispensing Considerations

Schedule II drugs may not be dispensed without a Prescribing Provider's written prescription or as allowed by applicable law for electronic prescribing ("e-prescribing"), except in emergency situations, or when dispensed directly by a Prescribing Provider.

A prescription for a Schedule II controlled substance may be partially filled to the extent permitted by applicable law.

A prescription for a Schedule II controlled substance may not be refilled. A separate prescription is required if a Prescribing Provider wishes to authorize continuation of a patient's use of a Schedule II prescription drug beyond the amount specified on the first prescription.

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 the Covered Person has insurance through more than one insurer. 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 [RelayHealth](#).

Pharmacies should not submit an E1 for pharmaceutical manufacturer copay assistance coupon programs as they are not considered Prescription Drug Services.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

Medicare and Medicaid Dual Eligible Covered Persons

In accordance with Section 42 CFR 422.504(g)(1)(iii), if a Pharmacy provides Prescription Drug Services to a Covered Person who is eligible for both Medicare and Medicaid, the Covered Person will not be held liable for payment and the Pharmacy must (a) accept the Medicare plan payment as payment in full, or (b) bill the Medicaid benefit plan.

Qualified Medicare Beneficiary Program

The Qualified Medicare Beneficiary (QMB) program is a State Medicaid benefit that assists low-income dual eligible beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copayments.

Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, states that all Medicare and Medicare Advantage providers may not balance bill QMB individuals for Medicare cost-sharing under any circumstances.

A value of 51 will be sent in the Benefit Stage Qualifier field (NCPDP field 393-MV) to notify the pharmacy that this claim is submitted under the Part D BIN/PCN, but the claim is NOT paid for by the Part D benefit plan, it IS paid for by the Part B benefit.

The Pharmacy should not attempt to collect cost-share for Medicare Part B covered drugs, but instead should attempt to bill Coordination of Benefits (COB) the beneficiary's Medicaid benefit plan. Providers who inappropriately balance bill the QMB individuals are subject to sanctions and possible termination from Prime's Networks.

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. If the claims system does not show the correct LIS status for the Covered Person, the Pharmacy is required by Medicare to accept BAE when presented at the POS.

Medicare also requires 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 Pharmacy must call Prime's Contact Center to request an immediate LIS status update in the claims system.
- The Pharmacy may submit the claim once the claim system is updated with LIS status.
- The 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 supporting BAE documentation to the Medicare Part D Sponsor, who will then work with CMS to update the Covered Person's LIS status in the CMS system.

For Covered Persons without supporting BAE documentation:

- The Pharmacy should determine if the Covered Person has less than three days of medication remaining (an "immediate need").
- The 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 the 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 their terminal illness (and related conditions) paid for by their hospice providers. Some medications submitted under Medicare Part D will reject at POS for Covered Persons in hospice care. If the claims system does not show the correct hospice status for the Covered Person, the Pharmacy is required by CMS to accept BAE when presented at the POS.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

If the Covered Person has never previously been in hospice:

- The 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 Pharmacy to give to the Covered Person.

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

- The 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 Coverage
 - › 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 and PCN are 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 in the Payer sheets on [Prime’s Website](#).

National Provider Identifier (NPI)

- **Pharmacy NPI** — A 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.

- **Prescribing Provider Identifiers** — Prime will only accept a valid, active, individual (Type 01) NPI. The Pharmacy must submit the correct Prescribing Provider Identifier at POS. Claims submitted without a valid Prescribing Provider NPI number will reject at POS. Reject code “619” will be displayed with message “PrescrTyp1NPI Required.” The Pharmacy may, through the use of a Submission Clarification Code (SCC), attest that the Prescribing Provider NPI number supplied at POS is or will soon be a valid NPI. The Pharmacy must submit the Prescribing Provider’s NPI for all Medicare Part D claims. Claims will be monitored on a daily basis to ensure they are submitted with the correct Prescribing Provider Identifier.

Prime will contact the Pharmacy to request that it correct any claims submitted with an invalid Prescribing Provider Identifier and update its system for future claims. Failure to resubmit the claim(s) or update the Pharmacy’s system for future claims with the correct identifier may result in termination from Prime’s Networks.

Documentation

Approved and/or confirmed verbal changes and clarifications to the Prescribing Provider’s prescription order must be documented on the original hard copy or electronically noted in the Pharmacy’s online system prior to dispensing. The Pharmacy should not request changes to a prescription for the sole purpose of avoiding POS messaging. For example, if a Pharmacy receives a POS message indicating a PA is required or that it must call Prime’s Contact Center, the Pharmacy is expected to follow the POS messaging and Prime’s Contact Center instructions. 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.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

Days' Supply for Non-Medicare Part D Claims

The 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 (such as inhalers), where the smallest unit exceeds the benefit days' supply, the Pharmacy must submit the maximum days' supply allowed under the Covered Person's Benefit Plan.

Example: Covered Person's benefit allows up to a 30-day supply. One inhaler will last 40 days. The Pharmacy must bill the inhaler as a 30-day supply.

In situations where one unit does not maximize the benefit's days' supply (such as inhalers) the 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.

Days' Supply for Medicare Part D Claims

The 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 (i.e., greater than 30 days or greater than 90 days). In these instances, the Pharmacy should submit the accurately calculated days' supply.

Example: Prolia for a 180-day administration should be submitted with a 180-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 days' supply (such as topical products). For these, the Pharmacy must submit the maximum days' supply allowed under the Covered Person's Benefit Plan.

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 (for example, clobetasol shampoo). The Pharmacy must bill the bottle as a 30-day supply.

In situations where one unit does not exceed the maximum benefit days' supply (such as inhalers) the 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 equal to or less than the quantity written and accurately reflect the exact quantity dispensed to the Covered Person. Submit the exact quantity, including decimal points, on claims and do not round up or down.

Dispensed Package Size/National Drug Code (NDC)

When the Pharmacy submits a claim for a Prescription Drug Service, the 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 Service 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 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 Pharmacy agrees to submit all claims online within 90 days of the date of dispensing the Prescription Drug Service, unless otherwise required by law.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

E-prescribing

The Pharmacy agrees to comply with applicable laws for e-prescribing.

Prescription Origin Code

The Pharmacy must submit all claims with the corresponding prescription origin code as outlined in the applicable payer sheets:

- › Written
- › Telephone
- › Electronic
- › Facsimile
- › Pharmacy

All claims submissions must indicate the prescription origin code in order to facilitate CMS reporting and tracking of e-prescribe participation. The documentation retained by the Pharmacy must support the prescription origin code submitted on the claim.

Requirements for Pharmacies Contracted with 340B Covered Entities

The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care entities at significantly reduced prices.

Duplicate discounts are prohibited under Prime's agreements with manufacturers and 42 USC 256b(a)(5)(A)(i), and drugs purchased at a discounted 340B price are not eligible for drug rebates. Pharmacies must comply with Prime's claims processing requirements for 340B claims by submitting "20" in the NCPDP Submission Clarification Code (42Ø -DK) field and "08" in the Basis of Cost NCPDP field (423-DN).

To view the specific claim processing requirements, please go to [Prime's Website](#).

Compound Prescription Billing Guidelines

Pharmacies must submit Compound Prescription claims through the POS system using the following directions:

- Submit Compound Prescription with a code of "2" in the Compound Code field.
- Submit a zero (0) in the Product/Service ID field in the claim segment and submit the information for each ingredient in the compound segment.
- Enter the product ID qualifier, NDC used to prepare the Compound Prescription, quantity, cost and cost basis for each ingredient in the Compound Prescription.
- Submit the final product quantity (the quantity of the finished Compound Prescription product) in the quantity dispensed field:
 - › 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, calculate the total sum 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 a Compound Prescription log with documentation for each Compound Prescription dispensed. The log must document quantities and NDCs of the ingredients used to prepare the Compound Prescription. NDCs submitted for the Compound Prescription must be the exact formulation of what is dispensed.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

- Prime will accept a multiple ingredient Compound Prescription submission using NCPDP's compound segment for up to 25 ingredients.
- Dynamic prior authorizations (PAs) for processing Compound Prescriptions 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 Compound Prescription claim meets the criteria for coverage under Medicare Part D.
- If a Compound Prescription claim rejects, the Pharmacy must follow POS messaging to determine if the ingredients submitted require a PA.

If a PA is required, the Pharmacy must follow the POS messaging to obtain a PA. If a PA is not required and one or more ingredients is not covered by the Covered Person's Benefit Plan, the Pharmacy may submit a clarification code of "08" to receive payment for all covered ingredients. Not all benefit plans support the use of clarification code "08."

- Each benefit set-up determines claim coverage and may vary by Covered Person. As the Compound Prescription claim is processed, the Pharmacy receives system messaging on the status of the submission. Pharmacies are required to follow all system messaging.
- Compound Prescriptions containing a Medicare Part B ingredient must be processed under Medicare Part B.

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 Prescriptions. Evidence of unprofessional or unsafe compounding found during the Pharmacy's audit process or otherwise may be reported to the applicable State Board of Pharmacy or the FDA, and may result in termination of the 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 Prescription 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
 - › 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 Prescription:

- 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, antibiotic IVs with only one legend drug).
- 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.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

- Any compound that has an equivalent commercial form, except in situations where a Compound Prescription is preferred according to the Benefit Plan. This exception may vary by state.

Prime also considers the following to be additional unacceptable billing practices for Compound Prescription claims:

- Billing for a different NDC than what was used in the Compound Prescription.
- Billing for the full package size when only a partial amount was dispensed to the Covered Person.
- Billing for a different dosage form than what was used in the Compound Prescription.
- Billing for a quantity other than what was actually used to prepare the Compound Prescription.
- Any Compound Prescription 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 Compound Prescription orders to avoid POS messaging.
- Phishing for a drug that pays (i.e. Pharmacy submits a claim for one drug, received a reject or reverses the claim and resubmits for a new drug within a short period of time).
- Billing each compound ingredient as a separate Prescription Drug Service claim.
- 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 Prescribing Provider /Covered Persons' relationship.
- Billing Compound Prescription claims for a Covered Person:
 - › Where there is not literature that supports the clinical use
 - › Where the 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 Pharmacy giving or receiving payment to or from any Prescribing Provider for referrals
- Balance billing for any products that are not eligible for payment determined by the plan sponsor and/or CMS.
- Billing for compounds where the final product is not prepared in compliance with USP guidelines.

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

Insulin and Diabetic Supply Benefits

- A valid prescription must be on file for insulin dispensed to a Covered Person.
- An emergency fill can be dispensed by the pharmacist as allowed by applicable law.
- Insulin should be dispensed within the days' supply limits set by the Covered Person's Benefit Plan.
- Specific dosing directions must be documented at the time of dispensing. If a sliding scale is used, the 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 otherwise indicated at POS, insulin syringes and needles are a covered benefit.
- A valid prescription is required for insulin supplies to be dispensed to a Covered Person.
- Some Benefit Sponsors will waive the Copay 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 this Manual.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

Long-Term Care (LTC) and Home Infusion (HI) Processing Requirements

Prime requires LTC and HI 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](#).

Hemophilia Billing Guidelines

Pharmacies are expected to maintain accurate records of a hemophilia patients' available on-hand supply in order to support appropriate future dispensing. Patient bleed records must be collected and maintained by the Pharmacy. Pharmacies are expected to ensure that patients have an emergency bleed supply on-hand for major and minor bleeds. If a bleed occurs, the Pharmacy may replenish the on-hand bleed supply.

Single use vials should be dispensed in a manner that most closely aligns with the prescribed dose and minimize waste. For example, Pharmacies are expected to process two separate size vials to most closely align with the prescribed dose. If a Pharmacy dispenses clotting factor with an assay of greater than 5% variance of the prescribed dose, the Pharmacy must document the reason the assay was not met at the time of dispensing. Factor products must have expiration dates of no less than one year from the date of dispensing unless there is specific documentation of discussing this with the patient or caregiver. Doses dispensed for as needed use for bleeds should not be dispensed with an expiration of less than one year. Pharmacies must not dispense more units per dose than what is necessary and must not dispense short-dated product.

Medicare Programs Coordination of Benefits (COB)

COB claims for Medicare Programs should be processed in Prime's claims processing system. 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 to 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 can send an E1 Eligibility Query to RelayHealth to determine proper payer order. Prime's Supplemental to Medicare Payer sheets are available on [Prime's Website](#).

Additional information on Medicare COB can be found at [CMS.gov](#).

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 limits 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 any drugs covered under Medicare Part A or Part B, such as drugs that are administered in a pump, covered under hospice benefits or End Stage Renal Disease (ESRD) benefits. 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.

In the event that insulin is being used in a pump, the Pharmacy must submit the claim to Medicare Part B. On applicable insulin products, a POS message will be returned on the claim that states "If used in non-disposable pump, submit to Medicare Part B." The Pharmacy must verify insulin is not being used in a pump before submitting the claim to pay under Medicare Part D. In situations where the Covered Person is using an insulin pump, the claim is not eligible for Part D submission.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

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. 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, Pharmacies may receive an NCPDP Reject Code of 569, indicating 'Provide Notice: Medicare Prescription Drug Coverage and Your Rights,' requiring the Pharmacy to distribute the Prescription Drug Coverage and Your Rights form. This written notice informs Covered Persons of their right to request and receive a coverage determination. The 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.

A 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 Pharmacy's obligation to reverse ineligible claims, Prime may, at its discretion, reverse ineligible Medicare Part D claims. Prime conducts outreach to 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 Pharmacies must reverse the identified claim(s) and resubmit to the Covered Person's correct Medicare Part A or Part B coverage. If the Pharmacy fails to reverse the claim as directed, Prime will reverse the claim on its behalf.

If a Pharmacy mistakenly 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 Pharmacy of the error. Retroactive recoupment for hospice drugs may be coordinated directly with the hospice and/or Covered Person.

Many Benefit Plans no longer require pharmacies to submit Part B covered products to separate BIN and PCN.

If a claim is submitted to the incorrect BIN/PCN, Prime will reject the claim with the following message:

- NCPDP Reject Code 85: Claim not processed, Please use the BIN/PCN on the member's ID card.

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 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. Drug Formularies can be accessed on [Prime's website](#).

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 monthly to reflect additions, deletions, tier changes and utilization management changes. Updated lists are posted monthly on [Prime's Website](#).

During the benefit year, a Benefit Sponsor may remove a brand name drug from the formulary and replace it with a new generic version of that drug on the same or lower cost-sharing tier and with the same or fewer restrictions (Utilization Management, for instance). The brand may remain on the formulary but may be subject to a higher cost-sharing tier or additional restrictions. These changes may be made with notice to affected Covered Persons after the change.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

If a Benefit Sponsor makes other types of Drug Formulary changes during the year, Prime will notify affected Covered Persons and Prescribing Providers at least 30 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, without the addition of a generic version of that drug.
- Changes to prior authorization (PA), quantity limits and/or step therapy programs to be more restrictive.
- Drugs that have moved to a higher cost-sharing tier, without the addition of a generic version of that drug.

If the FDA declares a drug to be unsafe, or the drug's manufacturer removes the drug from the market, then the drug will be removed from the Drug Formulary and Covered Persons who have received the drug will be notified.

Covered Persons may be notified of Drug Formulary changes by United States Postal Service, email or when they check their Plan Sponsor's website. Prescribing Provider and 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)

Below are the six (6) types of PAs used by Benefit Sponsors:

- **One-time override** — Used for a dosage change, vacation, lost/stolen, spilled, incorrect days' supply, damaged medication or request to dispense through mail rather than retail. At the time of the fill, the 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 Pharmacy's system automatically dates and time stamps the entry. The Pharmacy may request a PA for a dosage change or vacation request by calling Prime's Contact Center at **800.821.4795**.

- **Dynamic PA** — Some Benefit Sponsors use an automatic override process referred to as dynamic PA. A Pharmacy must enter 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 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 Pharmacy's system automatically dates and time stamps the entry. A Pharmacy may need to request a PA for a dosage change or vacation override.

The following PA's must be completed by the Prescribing Provider, Covered Person or Covered Person's Appointed Representative, as documented by a valid appointment:

- **Drug Formulary exception** — Used when a Prescribing Provider requests a medication for a Covered Person that is not in the Drug Formulary, for example when the Covered Person is sensitive or unresponsive to a therapeutic alternative in the Drug Formulary. If the Benefit Sponsor has elected to use this PA, Prime will provide the Pharmacy POS messaging for additional instructions on requesting a Drug Formulary exception. In no event shall the Pharmacy complete a PA for a Drug Formulary exception. The Pharmacy shall follow POS messaging and notify the Covered Person and/or Prescribing Provider of the need for a PA. There are three ways to obtain a Request for a Drug Formulary Exception form:
 - › The Prescribing Provider 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 his or her Benefit Sponsor's website

SECTION 3: CLAIMS PROCESSING (CONTINUED)

- **Clinical PA** — Used for medication that requires clinical review of 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 Prescribing Provider. In no event shall the Pharmacy complete a PA for Clinical PA. The Pharmacy shall follow POS messaging and notify the Covered Person and/or Prescribing Provider of the need for a PA. POS messaging may vary based on the drug or program and may include quantity limit, step therapy or clinical necessity requirements in addition to the PA. 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, medications used to treat Hepatitis C and compounds. These drugs will reject with the NCPDP reject codes of 75, “Prior Authorization Required” or 76 “Plan Limitations Exceeded.” For the most current information on medication that requires PA, visit the Covered Person’s Benefit Sponsor’s website.
- **Appropriate Payor Verification** — This PA is used specifically for certain drugs (such as Cialis and fentanyl) in Medicare Part D. Claims for these drugs should reject at POS and require a PA to determine that:
 - › The Covered Person’s use of that drug is eligible for coverage under Medicare Part D
 - › 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 review of a PA request for one of these drugs, it may be determined 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 or the Plan Sponsor 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:
 1. Laxatives
 2. Antiemetics
 3. Antianxiety agents
 4. 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 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 Prescribing Provider) 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. The Covered Person’s Prescribing Provider 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.

SECTION 3: CLAIMS PROCESSING (CONTINUED)

- If the Covered Person's eligibility incorrectly states that they are actively enrolled in Hospice and their claim for a drug in these four categories rejects at the Pharmacy, 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 Prescribing Provider 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 Pharmacy may request a Hospice PA Form by calling Prime's Contact Center at **800.821.4795**.

Electronic Submission of PA Requests Supported by CoverMyMeds

If the Pharmacy has received POS Clinical PA messaging, the Pharmacy may initiate an electronic PA request through CoverMyMeds.com. In any event, the Pharmacy must notify the Covered Person and/or Prescribing Provider indicating that a PA is required for the Prescription Drug Service. In no event, shall the Pharmacy submit a PA on behalf of a Prescribing Provider or Covered Person. See [CoverMyMeds](https://CoverMyMeds.com) for more information.

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 topical non-steroidal medications, xanthine oxidase inhibitors/renin Inhibitors, and proton pump inhibitors. For the most current information on step therapy, visit the Covered Person's Benefit Sponsor's website. Claims for drugs subject to step therapy 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. A claim that exceeds the quantity limit will result in a NCPDP reject code 76 "Plan Limits Exceeded." A free-form text message accompanies the rejection and indicates the maximum quantity that may be dispensed. A Pharmacy's software system must be able to capture the reject code and associated POS message. This section titled "Quantity Limit" does not apply to Prescription Drug Services where a 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 prescribed exceeds the quantity limit allowed by the Covered Person's benefit, the Pharmacy must reduce the quantity dispensed and adjust refills according to the quantity dispensed. If the Covered Person requests a smaller amount, the Pharmacy may reduce the quantity dispensed. The pharmacist should document this on the hard copy at the time of the fill or prior to dispensing on the electronic documentation to reflect the Covered Person's request. Electronic documentation must have a system-assigned user, date and time stamp in order to take the place of hard copy documentation.

Drug Utilization Review (DUR)

Prime will alert 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

SECTION 3: CLAIMS PROCESSING (CONTINUED)

- Additive toxicity screening
- Apparent Drug Misuse screening

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

Prime requires Pharmacies in Prime's Medicare Programs Network to review, update and/or implement quality assurance systems and procedures at the POS as required by CMS regulations. Pharmacies are required to obtain and refer to the Covered Person's allergy information before dispensing. In addition, Pharmacies must ensure that all employees or other agents who dispense medications 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 lists at Prime's sole discretion. The drug may be added back when Prime's market sources confirm adequate supply and distribution.

Please refer to [Prime's Website](#) for registration instructions to access Prime's MAC lists, weekly MAC changes, MAC pricing appeals process, and the sources used to determine MAC pricing. After Pharmacy Network participation is verified, the Pharmacy will receive a secure user name and password via email to access Prime's MAC lists.

SECTION 4: BENEFIT PLAN

POST CLAIM ADJUDICATION

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. Claims not reversed within 14 days for Prescription Drug Services that are not received by the Covered Person are subject to audit and may be collected through the retrospective pharmacy audit process.

BENEFIT PLAN

Benefit Plans may change without prior notice to the Pharmacy. New Benefit Plans may be added at the request of a Benefit Sponsor. The POS system will provide the Pharmacy with current Benefit Plan 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 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 the prescription hard copy or the electronically submitted prescription.

SERVICES PROVIDED TO FAMILY MEMBERS

In accordance with Covered Person's Benefit Plan, Prescription Drug Services prescribed by or provided to a family member may not be covered and such Prescription Drug Services may be identified after claim adjudication.

PRODUCT SELECTION CODE (PSC)

For purposes of this Manual, Dispense as Written (DAW) and PSC are used interchangeably. A 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: A Pharmacy must dispense a generic drug whenever permitted and in accordance with applicable laws. However, there are instances where the Prescribing Provider 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 Prescribing Provider. 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 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 Copay for PSC 1 or 2 may vary based on the Benefit Plan. 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 Pharmacy must dispense a generic drug whenever permitted and in accordance with applicable laws.

A Pharmacy must stock a variety of generic drugs coinciding with the habits of Prescribing Providers and/or Benefit Sponsor's Drug Formulary as indicated by the claims system response and other correspondence, and/or the generic Drug Formulary of the state in which the Pharmacy is located.

ENHANCED PHARMACY PROGRAMS

Vaccine Administration

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. Please refer to [Prime's Website](#) for up-to-date Vaccine program information.

“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 Pharmacy for administering a Vaccine by the act of injection in accordance with applicable law. A Pharmacy must submit its claim for the Vaccine Administration Fee to Prime electronically, along with the related ingredient cost submission and dispensing fee. In other words, 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 uses 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) and/or quantity limits (QL).

The transition process gives Covered Persons time to work with their Prescribing Provider 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 a Covered Person in their transition period (for example, within ninety (90) days of their eligibility) presents a prescription for a Part D drug that is not on the Medicare Part D Benefit Sponsor's Drug Formulary or is subject to certain limits such as PA, ST, and/or QL the paid transition claim will return the applicable NCPDP approved message code “004” to the Pharmacy explaining the drug paid due to the standard transition benefit.

SECTION 4: BENEFIT PLAN (CONTINUED)

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 Pharmacy will explain the reason. Messaging examples are provided below.

At retail, Covered Persons are allowed at least a one (1) month transitional supply of a non-formulary drug or a drug subject to certain limits. LTC Covered Persons are allowed up to a one (1) month transitional supply per fill during their transition period. The exception to the days' supply limits are drugs packaged in such a way that they cannot be dispensed for fewer days than the benefit limit (for example, Lupron Depot Inj. 11.25 mg which is prepackaged in a 3-month supply).

Pharmacies, including Extended Supply Network (ESN) and Mail Order pharmacies, may get a reject message indicating that a Covered Person may not obtain more than the days' supply limits noted above. However a claim may require other corrections or override codes, which should be done prior to reducing the days' supply. The claim may allow benefits if the corrections are made without reducing the days' supply to accommodate the transition days' supply limit. If the claim remains rejected after all other corrections or overrides have been completed, then action should be taken to resolve the transition days' supply reject indicated within the message.

Partial Fills

Since a Covered Person may have received a partial fill during the transition period, it is important to reference the message indicating days' supply remaining and check the Covered Person's history for the drug to see if the Covered Person is still eligible for the remainder of the transition.

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

Important Notice—To meet CMS requirements, **Covered Persons in transition must leave the Pharmacy with the appropriate medications.** 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 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 transition benefit. Pharmacists receiving these codes must communicate the information to the Covered Person and suggest that the Covered Person contact their Prescribing Provider to switch 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.

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 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 approved message code “004” will be returned.

SECTION 4: BENEFIT PLAN (CONTINUED)

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 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 approved message code “004” will be returned.

There are additional benefits that apply to Covered Persons transitioning to/from LTC as well. They include the following:

- The level of care change benefit applies to Covered Persons who switch care settings. This can occur when a Covered Person switches from LTC to retail, from retail to LTC or from one LTC setting to another. Early refill edits are not used to limit appropriate and necessary access to their Part D benefit. Such Covered Persons are allowed to access a refill upon admission or discharge. When there is a paid claim due to the level of care change transition benefit, the NCPDP approved message code “012” will be returned indicating:
 - › “Level of Care Change.”
- The emergency transition benefit applies to Covered Persons in the LTC setting.
- The emergency transition benefit allows up to a 31-day supply of Part D drugs that would otherwise reject non-formulary or be subject to certain limits. When there is a paid claim due to the emergency transition benefit NCPDP approved message 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

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 Dispensing requirements.
- Seven-day unit packages must be logged and billed no more than once per month.
- Controlled Substances require LTC facility (LTCF) to be documented on the prescription order.
- OTC products must be dispensed in the original container, and 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 except when the product is delivered to an LTC facility.
- If providing Prescription Drug Services to Covered Persons residing in an LTC facility, the Pharmacy shall maintain a delivery log to acknowledge delivery. The delivery log should include:
 - › The Prescription number
 - › Date of fill
 - › Delivery date and signature of Covered Person(s) receiving medication
 - › Receipts and other documentation showing the Copay (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](#).

SECTION 4: BENEFIT PLAN (CONTINUED)

Medicare Short Cycle Dispensing LTC Guidelines and Procedures

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

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

SECTION 5: RESPONSIBILITY OF PHARMACY

UPDATE INFORMATION WITH NCPDP

The National Council for Prescription Drug Programs (NCPDP) requires that Pharmacies submit pharmacy information updates directly to NCPDP. To submit additions, changes, deletions, current address, fax number or phone number, go to NCPDP's website at online.ncdp.org.

Prime receives and incorporates weekly NCPDP updates into Prime's system, which include changes to a 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 for Covered Persons to locate Pharmacies, Pharmacies must submit pharmacy information updates to NCPDP as soon as they are aware, but no later than 7 days, of any change.

OIG AND GSA EXCLUSION AND PRECLUSION LIST 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. Prime does not pay (either directly or indirectly) any individual or entity who has been excluded, suspended, precluded or otherwise declared ineligible from participating in any state or federal health care program (e.g. Medicare, Medicaid, etc.). Furthermore, Prime will reject a pharmacy claim for a Prescription Drug Service that is prescribed by an individual on the Preclusion List.

A Pharmacy has an obligation to make sure it does not employ, or contract with, any individual or business that is excluded, precluded or debarred from participation in Medicare or state health care programs. Exclusion and preclusion checks must be conducted prior to contracting or hiring and monthly thereafter. If a Pharmacy or a specific Pharmacy location is sanctioned by the OIG, excluded or precluded from participation in federal health care programs, the 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**

PHARMACY'S AFFILIATION WITH PSAO

For a copy of Prime's Pharmacy Participation Agreement, a Pharmacy should contact their PSAO.

Pharmacies must notify NCPDP immediately upon change of affiliations with a PSAO. Under no circumstances shall Prime be liable for any losses suffered by Pharmacy as a result of inaccurate, incomplete, or other misinformation conveyed to Prime via the regularly received NCPDP interfaces. Prime reserves the right to request credentialing documentation from a PSAO, when applicable.

On a weekly basis, the PSAO is required to provide Prime a list of pharmacies it intends to add to its organization. This information must be provided to Prime at least one (1) week before the effective date of the pharmacy's affiliation with the PSAO. Prime reserves the right to request additional documentation from the PSAO and/or pharmacy prior to adding the pharmacy to Prime's Networks. The following information is required:

- PSAO affiliation code
- Pharmacy NCPDP, name, address, and fax number
- Pharmacy ownership information (including name of registered owner or owner group and ownership interest)
- Name of Pharmacist in Charge
- Name of any other staff pharmacists employed by the Pharmacy
- Pharmacy type (i.e. retail, compounding, etc.) and
- The effective date of the PSAO and Pharmacy affiliation

SECTION 5: RESPONSIBILITY OF PHARMACY (CONTINUED)

THIRD PARTY PAYMENT RECONCILIATION COMPANY

Pharmacies must update the EFT and 835 health care electronic remittance advice forms located on **Prime's Website** upon using a Reconciliation Company for the first time or upon changing the Reconciliation Company.

RE-CREATION FEE

In the event Pharmacy, or Reconciliation Company, requests that Prime resubmit a properly submitted remittance advice, Prime may charge the Pharmacy a re-creation and resubmission fee ("Re-creation Fee") in the amount of fifty dollars (\$50.00). Prime shall separately invoice Pharmacy for all applicable Re-creation Fees which shall be due 30 days from the date of invoice.

RESPONSIBILITIES OF THE PHARMACY FOR MEDICARE PROGRAMS

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 pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery prior to 1/1/2020. Effective 1/1/2020, a pharmacy may offer a voluntary auto-ship program if accompanied by the following Covered Person protections and operational procedures:

- Pharmacy must require that a Covered Person enrolls or opts-in to an auto-ship program on a drug by drug basis only after the initial fill
- Pharmacy must obtain the Covered Person's consent to opt-in to the auto-ship program after the initial fill and Pharmacy cannot assume or activate a Covered Person's opt in at the same time as the initial fill for the Prescription Drug Service
- Pharmacy must allow the Covered Person or their designee to opt-out of the auto-ship program at anytime
- Pharmacy must provide two separate successful and complete shipping reminders prior to auto-shipping the Prescription Drug Service
- Pharmacy must cease auto-shipments upon becoming aware that the Covered Person has entered a skilled nursing facility, hospitalized elected hospice service, died or the Prescription Drug Service is now covered under Medicare Part A or B
- Pharmacy must provide a full refund for any Prescription Drug Service dispensed under their auto-ship program that is not wanted by the Covered Person for any reason. The full refund must be applied for both new Prescription Drug Services ordered by the Prescribing Provider and auto-shipped refills.
- Pharmacy cannot require as a condition for a refund for a Prescription Drug Service that the Covered Person must return unwanted medications

This helps control FWA as required by 42 CFR § 423.504, and ensures that Medicare Covered Persons only receive new prescriptions and refills as requested. CMS and Medicare Part D Benefit Sponsors receive many consumer complaints of unneeded prescriptions being sent as part of auto-ship refill programs.

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

Pharmacies must (when instructed through POS messaging) 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**.

Pharmacies must comply with CMS' Medicare Marketing Guidelines, when applicable. If Prime or a Benefit Sponsor identifies a communication that does not comply with CMS' Medicare Marketing Guidelines, Pharmacies must remove or revise the communication as requested by Prime or a Benefit Sponsor.

SECTION 5: RESPONSIBILITY OF PHARMACY (CONTINUED)

PHARMACY CREDENTIALING

Prime credentials pharmacies prior to entry into Prime's Networks. A new pharmacy must complete a credentialing exhibit and supply all of the supporting documents so Prime can review and process the application. It is the pharmacy's responsibility to provide requirements outlined in Exhibit. Prime re-credentials all Pharmacies at least once every three years in accordance with applicable law and contractual obligations. Prime follows non-discriminatory practices in the credentialing process. Participation in Prime's Network(s) is not based on factors such as race, religion, gender/gender identity, color, national origin, age and sexual orientation.

Re-credentialing is a requirement for continued participation in Prime's Networks. Failure to complete the re-credentialing exhibit will be cause for termination.

All Pharmacies must provide Prime with updated copies of the following documents upon their expiration:

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

Pharmacies must include their pharmacy name and NCPDP number on each of the required documents. The Pharmacy must label required documents as outlined in Exhibit.

Pharmacies must provide accurate information on their credentialing application, and notify Prime in writing within seven (7) business days if any information changes.

Pharmacies must meet Prime's credentialing criteria, which are determined at Prime's sole discretion. These criteria include, but are not limited to, Prime's billing thresholds for compound prescription drugs, non-FDA approved drugs, single ingredients and products as determined by Prime, based on information obtained by Prime at any given time.

Prime reserves the right to decline or terminate all Pharmacies under the same ownership or control when the Pharmacy is determined to be in violation of the Agreement, the Provider Manual or applicable law.

APPROPRIATE DISPENSING PRACTICES

When dispensing medications, Pharmacies must be diligent in determining that claims are submitted for a valid use of a medication. Pharmacies must be aware of prescription orders that are prescribed and dispensed for dosage strengths and routes of administration that are not consistent with manufacturer prescribing information. When reviewing claims, auditors may request documentation to support appropriate dispensing of medications based on standard industry practice.

Documentation of scientific evidence that meets the expectation will demonstrate efficacy and safety for the requested use. The documented evidence must show:

- Consistent and adequate number of well-designed studies with sufficient numbers of patients in relation to the incidence of the disease.
- Publication in major peer-reviewed journals that only publish original manuscripts after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability.
- Consistent results across all studies for that specific disease and treatment.
- Positive health outcomes including demonstration that the drug is as effective as or more effective than FDA-approved alternatives.

The following types of documentation do not meet the expectation of standard industry practice:

- Clinical studies administered without direct correlation to intended use, strength, dosage form, and/or route of administration.
- Manufacturer sponsored studies with results that have not been approved by the FDA.
- Off-label use does not have a level of evidence for the indication that is Micromedex DRUGDEX® Class I or Class IIa level of evidence or from National Comprehensive Cancer Network (NCCN) category of evidence Class I or Class IIa.
- Patient case reports.

SECTION 5: RESPONSIBILITY OF PHARMACY (CONTINUED)

SIGNATURE OR DELIVERY LOGS

The Pharmacy shall ensure that all Covered Persons (or his or her authorized agent) who receive a Prescription Drug Service signs the signature or delivery log, acknowledging the date the Prescription Drug Service was received and the applicable prescription number. Prime may request signature and/or delivery logs for Prescription Drug Service(s) at any time.

LONG-TERM CARE (LTC) AND HOME INFUSION (HI) ANNUAL VALIDATION PROCESS

Prime requires each Pharmacy that participates in these Pharmacy Networks to annually validate that they are able to comply with guidelines outlined for participation in the HI and/or LTC Pharmacy Networks.

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

TERMINATION APPEALS

Pharmacies have thirty (30) days from the date of notification of termination or an extended time as required by law to submit a termination appeal. Appeals must be submitted in writing and include the Pharmacy's name and an explanation of the appeal. Terminations will be deemed finalized if an appeal is not received by Pharmacy within the thirty (30) days from the date of notification of the termination or an extended time frame as required by law. 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**.

Prime reserves the right to terminate a Pharmacy from Prime's Network(s) for up to five (5) years, depending on the reason for termination.

CONFIDENTIALITY AND PROPRIETARY RIGHTS

Confidentiality

Any information or data obtained from, or provided by, Prime to the Pharmacy is confidential ("Confidential Information"). Confidential Information 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 documents provided by Prime or any Benefit Sponsor.

- The Pharmacy shall not sell, assign, transfer, disclose or give Confidential Information to any third party without the prior written consent of Prime.
- No Confidential Information may be quoted or attributed to the Pharmacy or Prime without the prior written consent of Prime.
- The Pharmacy must use all necessary security procedures to ensure protection of all Confidential Information from improper access.
- The 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 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. The Pharmacy must establish privacy and security safeguards in accordance with applicable law and as appropriate and necessary.
- The Pharmacy must promptly notify Prime if it becomes aware of any unauthorized use of Confidential Information.

SECTION 5: RESPONSIBILITY OF PHARMACY (CONTINUED)

Proprietary Rights

Except as required to fulfill the Pharmacy's obligations under the Agreement, the 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 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.

Recall Notices and Expired Medication

The Pharmacy is responsible to monitor and respond to all recall notices and remove any impacted drugs from the Pharmacy's inventory immediately or as otherwise indicated in the recall notice. The Pharmacy must notify any Covered Persons whom have received Prescription Drug Service for recalled; work with the Prescribing Provider and Covered Person to provide an alternative Prescription Drug Service, as applicable; and document all actions taken. Additionally, the Pharmacy must maintain and document a process to ensure all expired drug products are removed from the Pharmacy's stock routinely.

MANUFACTURER ASSISTANCE REPORTING

Some Benefit Plans limit or exclude direct manufacturer assistance amounts from a Covered Persons' annual limitation on cost sharing. To comply with these Benefit Plans, the Pharmacy must provide Prime with information on direct manufacturer assistance, including but not limited to coupons, including those through RelayHealth or other switch operators, and manufacturer sponsored copay assistance programs. To view the specific manufacturer assistance reporting requirements, please go to [Prime's Website](#).

SECTION 6: PHARMACY OVERSIGHT

PHARMACY OVERSIGHT

Oversight of Pharmacies is a critical component of responsible pharmacy benefit management. Prime manages a robust pharmacy oversight program to detect inaccurate payments, drug waste, and fraudulent claims or other benefit coverage abuses. As part of this program, Prime regularly samples and reviews claims submitted by Pharmacies in Prime's Networks.

Prime conducts claim audits, onsite audits, and investigations ("oversight activities") to monitor compliance with state and federal regulations, Prime's Pharmacy Participation Agreements and this Manual. These activities verify the integrity of claims submitted to Prime and payments made to Pharmacies. Through the oversight activities Prime reviews the accuracy of the claim information submitted to Prime in order to identify instances of potential FWA.

Findings related to Prime's oversight activities of Pharmacies may result in pharmacy payment recoupment, claim adjustment, remediation, termination from one or more of Prime's Networks and/or termination of the Pharmacy Participation Agreement. For purposes of the Pharmacy Oversight section, please see the specific criteria found in the guidelines located in the Pharmacy Audit section on [Prime's Website](#).

EDUCATION

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

ACCESS TO PHARMACY RECORDS

Pharmacies must provide Prime with adequate access to their records related to Prescription Drug Services provided under the Agreement. This includes, but is not limited to:

- Wholesaler invoices and pedigrees
- Prescription orders
- Signature log/delivery log
- Licensing
- Proof of insurance
- Dispensing history
- Proof of copay collection
- Business agreements or contracts with Prescribing Providers
- Bill of sale documentation regarding Pharmacy purchase, when applicable
- Past and current employee lists
- Standard operating procedures

Prime reviews these records to compare the submitted claim information to the original source documentation, such as the prescription order and other relevant documentation to confirm the accuracy and legitimacy of the claim submitted to Prime.

Pharmacies shall not photograph or record (either audio or video) interactions with Prime personnel, including telephone discussions, onsite audits, security camera footage or other interactions without Prime's prior written consent. Such activity may result in termination of the Pharmacy Participation Agreement.

EXPENSES

Pharmacies may not charge Prime for pharmacy personnel time involved in responding to Prime's oversight activities. Each Pharmacy is responsible for its own expenses, including production of any records to Prime.

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 Pharmacy at the time of dispensing. 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 to take the place of hard copy documentation.

The Pharmacy must retain all documentation related to a prescription claim in accordance with the Pharmacy Participation Agreement and applicable state and federal laws.

A prescription is considered valid when the original prescription order 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 Prescribing Provider and, if the prescription is for a controlled substance, the Prescribing Provider’s DEA number. If the Prescribing Provider did not include their NPI/DEA number(s) on the prescription hard copy, then the pharmacy is responsible for acquiring the Prescribing Provider ID either from the pharmacy’s claim system or by contacting the Prescribing Provider.
- The Pharmacy must document correct Prescribing Provider ID on the prescription hard copy or on a prescription label, affixed to the back of the prescription hard copy.
- Name of medication and strength prescribed
- Quantity authorized by the Prescribing Provider
- **Specific dosage change**—The medication dispensed to the Covered Person must be labeled with the Prescribing Provider’s direction for use. The Pharmacy must obtain specific directions for use to accurately dispense the prescription. Specific directions for “Use as Directed” are required. The directions “As Directed” is not allowed. Directions may be obtained through direct communication with the Prescribing Provider or, if the Prescribing Provider is unavailable, 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 Prescribing Provider at the time of dispensing. For drugs that are administered on a sliding scale, such as insulin, the Pharmacy must obtain and document the dosage range or maximum per day prior to dispensing.
- **Substitution instructions with appropriate documentation**—When medically necessary, the Prescribing Provider may write “Dispense as Written” on the prescription, or in the case of a telephoned prescription order, the pharmacist must write “Dispense as Written” on the telephoned prescription order. If a Covered Person requests a brand-name drug, the Pharmacy must document the request on the prescription order.
- **Refill** —If there are no refills indicated by the Prescribing Provider, the Pharmacy should assume that there are no refills. If refills are added to a prescription, the Pharmacy must retain written documentation of the authorization and assign a new prescription number.
- **Prescription number**—The prescription hard copy must be labeled with the corresponding prescription number. If the prescription is for a drug under a federally regulated program (for example, iPledge, or S.T.E.P.S. Data 2000), the Pharmacy must document the authorization number obtained from the program on the prescription hard copy before dispensing.

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

- Documentation of the date the prescription was received and the name of the caller for verbal or telephoned prescription orders, changes to prescription order or clarification to any order.
- Prescription hard copies missing one or more of the required elements may be considered invalid.

PRESCRIPTION LABEL REQUIREMENTS

The prescription label must contain the following elements, in addition to other elements required by state and federal guideline:

- Full name of Covered Person
- Full name of Prescribing Provider
- 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

PRODUCT PURCHASE REQUIREMENTS

Pharmacies must purchase all products and supplies being dispensed to Covered Persons from authorized traders, in accordance with Federal Law. The ordering of these products and supplies must be tracked using verifiable invoices and pedigree invoices when required by applicable law. Prime reserves the right to not accept documentation from any authorized traders at any time when the invoice documentation cannot be verified or does not comply with applicable law.

PURCHASE INVOICES AND PEDIGREES

Prime may request that a Pharmacy authorize their wholesaler(s) or manufacturer(s) to submit invoices and/or pedigrees to Prime to verify purchase and demonstrate that the products billed to Prime were purchased from a legitimate source. The Pharmacy must promptly comply with such requests. Wholesaler invoices received must be verifiable. Pharmacies are responsible for validating that each of its own wholesalers has valid pedigree documentation.

REVIEW OF CLAIM SUBMISSION

Prime 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 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. A Pharmacy must submit the originally prescribed product in order to determine if the drug is covered by the Covered Person's Benefit.
- **NDC**—The NDC on the claim must correspond to the NDC used to dispense the prescription.
- **Price**—The accuracy of the calculating and submitting price is based on the NDC's and quantities used to dispense the product.

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

Insulin Vials Billing Guide

Prescribed Units Per Day								
Qty	40	60	80	100	120	140	160	200
10 mL	25	N/A	N/A	N/A	N/A	N/A	N/A	N/A
20 mL	50	33 30/ 31*	N/A	N/A	N/A	N/A	N/A	N/A
30 mL	75	50	37 30/ 31/ 34*	30	N/A	N/A	N/A	N/A
40 mL	100 90*	66	50	40	33 30/ 31*	28	25	N/A
50 mL	N/A	83	62	50	41	35 30/ 31/ 34*	31 30*	25
60 mL	N/A	100 90*	75	60	50	42	37 30/ 31/ 34*	30
90 mL	N/A	N/A	112	90	75	64	56	45
*Insulin vial products must be dispensed in a manner that most closely aligns with the prescribed dose and maximum benefit to minimize waste. Pharmacy must bill a slightly lower day supply of 30, 31, 34, or 90 days depending on the member's benefit and the actual day supply the medication will last.								

- **Insulin pen products**—The Pharmacy must break boxes of multiple insulin pens to bill as close to Covered Persons' allowed Benefit Plan without exceeding the quantity allowed under the Benefit Plan.
- **Product Selection Code (PSC)**—PSC submissions will be verified. When the Covered Person requests the brand-name drug, the 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 Pharmacy must document on the original hard copy and submit the claim with a DAW-8.

- **Quantity**—The Pharmacy must dispense the quantity as written and supported by the dosing directions unless the quantity written exceeds the Covered Person's Benefit Plan, the quantity written is for greater than the amount needed for the timeframe needed based on use instructions (i.e. writing for 20 doses per month when directions are to infuse 3 times weekly) or unless the quantity written is intended to be dispensed only if certain situations occur (i.e. hemophilia bleed dose replacement upon submission of infusion records). The Pharmacy must comply with POS messaging, including but not limited to, messaging regarding the Covered Person's Benefit Plan limit and must document the reason for dispensing a lesser quantity on the original prescription. If the POS messaging on the claim requires a PA, the Pharmacy must follow POS messaging and not reduce the quantity. To prompt accurate POS messaging, the Pharmacy must accurately represent the days' supply based on the quantity dispensed and directions for use on the prescription order.
- **Days' supply**—The Pharmacy must submit the correct days' supply, based upon directions for use. The 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. A Pharmacy must submit 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 Pharmacy must obtain the appropriate prescription order based on the drug class.
- **Auto-ship refills**—Prime requires Pharmacies to obtain patient consent prior to enrolling a prescription in auto-ship refill programs. This is to control FWA and ensure Prime's Covered Persons only receive new prescriptions and refills as requested.

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

- **Claim edits**—If the Pharmacy receives specific messaging when a claim is submitted, the Pharmacy must ensure that documentation is maintained to support the use of dynamic PA (override or DUR override) numbers or clarification code.
- **Prescribing Provider ID number**—The Pharmacy must enter the correct and valid Prescribing Provider’s ID number on the claim submission.
- **Usual and Customary (U&C)**—The Pharmacy will submit the lowest price the Pharmacy would charge a customer that was 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, coupons, discount card programs and other special discounts used to attract customers.

Prime relies on the original documentation provided in the audit or an investigation. Documentation that conflicts with or is inconsistent with the documentation provided in response to an audit or investigation will not be accepted during the appeal process.

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 copay that is applicable. The Pharmacy must submit the correct days’ supply, based on directions for use and benefit limitations (for example, incorrectly calculating the days’ supply for 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 of claim submission must be reversed through the electronic claim system.
- **Use as directed**—The Pharmacy must determine the specific dosing directions to accurately calculate the days’ supply and correctly submit the claim to Prime. The Pharmacy must contact the Prescribing Provider to clarify any ambiguous directions (such as “Use as Directed,” no directions documented or “As needed”) and document them on the prescription hard copy. If the Prescribing Provider is unavailable, communication with the Covered Person is acceptable and must be documented.
- **One prescription for the 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 commonly misbilled medications, visit [Prime’s Website](#).

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

UNACCEPTABLE BILLING PRACTICES

Based on the claim submission requirements, the following are examples of unacceptable and, in some cases, fraudulent practices which include but are not limited to:

- Billing for a legend or OTC drug without a prescription or benefit-sponsored voucher.
- Submitting incorrect information on claims that may lead to 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 quantity of a legend drug that exceeds the total prescribed quantity.
- Billing for a higher priced drug when a lower priced drug was prescribed and/or dispensed.
- Billing multiple loading doses instead of the appropriate subsequent maintenance dosages.
- Dispensing a generic drug but billing for the brand name drug.
- Submitting claims 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.
- Billing compound products in a manner inconsistent with Prime's credentialing criteria and/or the compound billing requirements described in the Compound Drugs Billing Guidelines of this Manual.
- Applying an expiration date on the prescription order that is earlier than the date the product expires according to the manufacturer.
- Misrepresenting the U&C.
- Billing the Covered Person for any associated recovery.
- Misrepresenting the origin code.
- Billing for drugs that were never purchased by the Pharmacy.
- Billing for drugs associated with wholesaler invoices that the respective wholesaler denies providing to the pharmacy because the drugs were not purchased from the wholesaler.
- Billing for drugs from a wholesaler that cannot provide drug ancestry or pedigree documentation supporting the legitimate purchase record of the drug.
- Submitting a claim for a non-FDA approved drug (such as compound kits and patches).
- Billing greater vial size than what is necessary to supply the ordered dose.
- Billing for drugs that are cyclic as continuous days supply (e.g. 21 day cycle billed as 28 days).
- Billing for weight based drugs without weight dosing calculations.
- Failure to implement documentation or process changes communicated via a previous audit.
- Billing high cost products when lower cost alternative products are available.
- Billing for drugs that the Covered Person did not authorize to dispense.
- Billing for drugs that the Prescribing Provider did not order.
- Billing for drugs where the Covered Person and the Prescribing Provider do not have a valid patient-Prescribing Provider relationship.
- Billing for drugs where the Pharmacy does not have a valid prescription order.
- Billing for a therapeutic interchange medication without contacting the Prescribing Provider before the claim is submitted to confirm the interchange.
- Billing for prescriptions during posted business hours when the Pharmacy is not physically open.
- Billing for prescriptions in order to bypass the POS edits or messaging.

RECOVERY OF PHARMACY PAYMENTS

Prime will collect improper payments paid to Pharmacies in a manner determined by Prime in its sole discretion. Pharmacies will be informed of payment off-sets through the standard remittance advice. Pharmacies will receive a report of claim adjustments performed directly by Prime.

REASONS 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 Prime's requests for documentation.
- Prime identifies billing issues through the claim audits.
- Referral from Prime's Fraud Tip Hotline or other sources that indicate potential FWA.
- Routine audit of pharmacies selected on a random basis.

AUDIT TIME FRAME

Claims selected for audit through the daily claim audit process generally include prescriptions billed to Prime within the previous fourteen (14) days. Historical claim audits generally include prescriptions billed to Prime within the previous twelve (12) months. Standard onsite audits generally include prescriptions billed to Prime within the previous twenty-four (24) months. However, Prime has the right to audit and/or investigate 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 program claims, or as otherwise permitted by law.

TYPES OF AUDIT ACTIVITIES

Daily and Historical Claim Audits

Prime monitors claims data to identify potential billing and compliance errors. When Prime identifies potential pharmacy errors shortly after adjudication, Prime contacts the Pharmacy who is instructed to correct the claim. This process is intended to educate Pharmacies on Prime's billing requirements and helps avoid retrospective audit recoveries. If the Pharmacy does not respond to Prime's requests or fails to correct improperly billed claims, impacted claims may be resubmitted or reversed by Prime, in its sole discretion.

If a claim is identified for audit, Prime will contact the Pharmacy via telephone, email or facsimile to inquire about the claim. Requested documentation may include, but is not limited to:

- Photocopies of the original prescription order, front and back
- Signature or delivery logs
- Receipts and other documentation showing the copay (if applicable) paid by the Covered Person or their representative
- Tracking number from delivery log, which must link to the prescription number and date of service that was delivered
- Computer records
- Wholesaler, manufacturer and/or return vendor invoices
- Pedigree invoices or documentation to confirm traceability of the medication from the manufacturer
- Compound information including all ingredients with NDC's and quantities used to prepare the compound claim
- Dispensing logs
- Bleed and dispensing logs for hemophilia products
- Documentation to include patient on hand quantities of prescription for prophylactic and as needed doses
- Weight based dosing documentation
- Prescription label

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

- Pharmacy and Pharmacist-in-Charge Liability Insurance
- Professional Insurance information
- Proof of FWA training
- License information
- Bill of Sale
- Documentation to support appropriate dispensing of medications based on standard industry practice
- Attestation of compliance with specific state and/or federal statutes, regulation, or CMS guidance

If a Pharmacy processes Long Term Care (LTC) Facility claims the following additional information may also be requested:

- Demographic information of any LTC facilities that were serviced by the Pharmacy during the time frame of the audit and/or investigation
- Medication administration records of the Pharmacy and/or the LTC Facility
- LTC Facility census information for the Covered Person during the audit and/or investigation that provides information on Medicare Part A stays

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

Prime communicates with Pharmacies throughout the claim audit process and before claim adjustments are made. Despite these efforts, there may be instances where the Pharmacy identifies additional supporting documentation after the claim has been adjusted. The additional information is reviewed through the claim audit grievance process within 14 (fourteen) calendar days. Pharmacies may submit in writing any additional supporting documentation for claims where the pharmacy does not agree with the claim audit outcome based on the original documentation provided. Pharmacies should provide the additional documentation to the auditor via fax or email.

Government Programs Fax:

- 877.290.1516
- 866.466.7686

Commercial Fax:

- 877.825.7404
- 877.263.5543

Email: pharmacyaudit@PrimeTherapeutics.com

If you suspect FWA involving the Federal Employees Plan by a Covered Person, Prescribing Provider, Pharmacy or anyone else, notify Prime:

Phone: **844.765.9990**

Email: FEPreportfraud@PrimeTherapeutics.com

Mailing Address:

Prime Therapeutics LLC

ATTN: Pharmacy Audit

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

A Prime auditor will review the requested claims to verify that the claims have been submitted in compliance with the Pharmacy Participation Agreement and Prime Provider Manual. Pharmacies will receive a claim adjustment report for those claims adjusted directly by Prime.

ONSITE AUDITS

Pharmacies selected for onsite audit may receive advanced written notice from Prime. Advance notice may not be provided at Prime's discretion, as allowed by law. If Pharmacies cannot accommodate an onsite audit on the scheduled date, Pharmacies may request alternative arrangement in advance of the onsite audit date. Prime will consider such requests on a case by case basis.

Onsite audits are conducted during regular business hours. Prime makes reasonable efforts to minimize disruption to all areas of the Pharmacy. Pharmacies are expected to provide Prime with access to the pharmacy and the documentation to support the claims submitted during the audit period should be readily retrievable and accessible.

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

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 onsite, the auditor will observe the Pharmacy practices and review all related documentation. The auditor may request to observe the Pharmacy's dispensing practices, including review of prescriptions pending member pickup. An interview will be completed with pharmacy personnel, preferably with the Pharmacist-In-Charge (PIC).

Requested documentation may include, but is not limited to:

- Photocopies of the original prescription order, front and back
- Prescription label
- Signature or delivery logs
- Receipts and other documentation showing the copay (if applicable) paid by the Covered Person or their representative
- Tracking number from delivery log, which must link to the prescription number and date of service that was delivered
- Bleed and Dispensing Logs for Hemophilia products
- Documentation to include patient on hand quantities of prescription for prophylactic and as needed doses
- Weight based dosing documentation
- Computer records
- Wholesaler, manufacturer and/or return vendor invoices
- Pedigree invoices or documentation to support wholesaler(s) purchases to confirm traceability of the medication from the manufacturer
- Compound information including all ingredients with NDC's and quantities used to prepare the compound claim
- Pharmacy and Pharmacist-in-Charge Liability Insurance
- Professional insurance information License information
- Proof of annual FWA training

- Pharmacy Bill of Sale, if applicable
- Documentation to support appropriate dispensing of medications based on standard industry practice
- Attestation of compliance with specific state and/or federal statutes, regulation, or CMS guidance

If a Pharmacy processes Long Term Care (LTC) Facility claims the following additional information may also be requested:

- Demographic information of any LTC facilities that were serviced by the Pharmacy during the time frame of the audit and/or investigation
- Medication administration records of the Pharmacy and/or the LTC Facility
- LTC Facility census information for the Covered Person during the audit and/or investigation that provides information on Medicare Part A stays

Onsite audits will involve the disclosure of Covered Persons' Personal Health Information (PHI) for the purpose of disclosure of treatment, payment or health care operations. For Prime and the Pharmacy to remain HIPAA compliant, a Pharmacy staff person is required to retrieve documentation; however, the auditor must be present to observe the documentation retrieval.

Pharmacies may not refuse to comply with an onsite audit on the grounds that it violates HIPAA or other relevant privacy laws.

A Prime auditor will review the claims for accuracy and 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 and education verbally while onsite at the Pharmacy.

Pharmacies must cooperate with an onsite audit.

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

REPORTING ONSITE AUDIT RESULTS

Following the onsite audit, Prime will provide the Pharmacy with a written preliminary audit report, which will include details of any discrepancies or relevant audit findings, as required by applicable law.

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 Pharmacy's claim submission

The Pharmacy will be provided a date by which any additional documentation supporting the claims may be provided to Prime by the Pharmacy. Prime will review additional documentation received. A final audit report will be issued to the Pharmacy after review of the additional documentation received or after the due date to provide additional documentation has passed.

ONSITE AUDIT APPEAL PROCESS

Pharmacies have thirty (30) days from the date of final audit report is issued by Prime to submit an appeal or an extended timeframe as required by law or regulation. Appeals must be submitted in writing and include the Pharmacy's name, the claims/prescriptions being appealed, any additional documentation not provided at the time of audit and an explanation of the appeal. Please see the Pharmacy Audit Guidelines for post-audit documentation accepted by Prime. Audit findings, including associated recoveries, will be deemed finalized if an appeal is not received by the 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 provided by the Pharmacy as part of its audit appeal may result in additional findings. Appeal results are considered final. For a copy of Prime's Pharmacy Audit Appeal form and Prime's Audit Guidelines, visit [Prime's Website](#).

- Documentation that conflicts with the initial documentation submitted will not be accepted during the appeal process.
- Prescribing Provider or Covered Person attestations received to support the manner in which a claim is submitted must be received directly from the Prescribing Provider or Member.
- Appeals received after the due date will not be considered.

CORRECTIVE ACTION PLAN (CAP)

Pharmacies may be placed on a corrective action plan, as determined by Prime in its sole discretion. Pharmacies subject to a corrective action plan are monitored to determine whether the identified issues have been remediated. If issues are not resolved to the satisfaction of Prime, additional remedial 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.

PHARMACY INVESTIGATIONS

Prime may conduct an investigation of any Pharmacy when Prime suspects or identifies potential FWA. During an investigation Prime may request access to the Pharmacy's facilities, personnel and any supporting documentation to support claims submitted to Prime during the investigative time frame. Pharmacies may not receive notification in advance of an onsite investigation. Timing of communications and reports to the Pharmacy may vary. Prime may record or video interviews conducted in person or via telephone for fraud investigations, as permitted by state law. Prime will issue applicable reporting to the Pharmacy throughout the investigative process. Prime reserves the right to terminate all pharmacies under the same ownership or control based on the results of an investigation.

Pharmacies must comply with investigations conducted by Prime.

SECTION 6: PHARMACY OVERSIGHT (CONTINUED)

REMEDIATION ACTION

Pharmacy audits and investigations may identify a Pharmacy's failure to comply with Prime's terms and conditions. As noted in the Introduction to Prime Therapeutics, failure to comply with Prime's contractual terms and conditions, including but not limited to, those described in the Manual, may result in placement on a corrective action plan, full or partial financial recoupment, network termination or other remediation actions, as determined by Prime. A Pharmacy may be immediately terminated from Prime's Network(s) upon Prime's receipt of any evidence of a Pharmacy engaging in activities that may result in FWA.

SECTION 7: MEDICAID REQUIREMENTS

GENERAL MEDICAID PROGRAM INQUIRIES

For general inquiries related to the Medicaid Programs please call:

- BCBSMN Blue Plus: **844.765.5940**
- BCBSIL Family Health Plan: **855.457.0173**
- BCBSIL Community ICP: **888.274.5218**
- BCBSNM Community Centennial: **888.840.3044**
- BCBSTX Children's Health Insurance Program (CHIP): **855.457.0403**
- BCBSTX State of Texas Access Reform (STAR): **855.457.0405**
- BCBSTX STAR Kids (Travis service area): **855.457.0757**
- BCBSTX STAR Kids (MRSA Central service area): **855.457.0758**

GENERAL MEDICAID REQUIREMENTS

Pharmacy Disclosure Statement

Pharmacies who participate in Medicaid Programs must complete a Pharmacy Disclosure Statement to comply with federal and/or state regulations. Pharmacies must complete Prime's Pharmacy Disclosure Statement when requested, and if there is any change in ownership, Pharmacy must submit a new Pharmacy Disclosure Statement.

ILLINOIS MEDICAID REQUIREMENTS

Automatic Refills

The use of automatic refills by Pharmacies in Prime's Illinois Medicaid Network is not allowed. All Prescription Drug Services refills must be initiated by a request from the physician, Covered Person, or other person acting as an agent of the Covered Person, e.g., a family member. Any Prescription Drug Services with remaining authorized refills does not constitute a request to refill the prescription. The Illinois Department of Healthcare and Family Services (HFS) will not reimburse a Pharmacy for any Prescription Drug Service that has been filled using an auto refill process. Any claim for a Prescription Drug Service filled without a request from the Prescribing Provider, Covered Person, or agent of the Covered Person will be subject to recovery. Claims for Prescription Drug Services that have been filled using auto refill and inadvertently billed to HFS must be reversed by the Pharmacy.

SECTION 7: MEDICAID REQUIREMENTS (CONTINUED)

MINNESOTA MEDICAID REQUIREMENTS

Automatic Refills

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

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

Do Not Accept Cash Payment

As a general reminder, Pharmacies may not accept a cash payment from a Covered Person or from someone paying on behalf of the Covered Person, for any MHCP Prescription Drug Service.

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

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

A 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 a cash payment authorization, the Prescribing Provider must contact the MHCP help desk at **800.366.5411** and explain 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 Prescription Drug Services, the 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, a pharmacy can accept cash as payment.

Cash for Phentermine

Pharmacies may accept cash for phentermine prescription drug claims as advised by the MHCP. Phentermine is not covered by Medical Assistance because weight loss drugs are excluded from coverage pursuant to Minnesota state law.

A Pharmacy may accept cash payment for a phentermine prescription drug provided that:

- The phentermine prescription drug is being used as part of a comprehensive weight loss program and is prescribed at the FDA-approved dosage.
- The Prescription Drug Monitoring Program has been reviewed and determined that the phentermine prescription drug is not being abused or overused.
- The Covered Person has been informed about the responsibility for payment before the phentermine prescription drug was dispensed.
- The Pharmacy or an authorized health care representative completes the **Advance Recipient Notice of Non-covered Prescription (DHS-3641) (PDF)** and the Covered Person signed the form.

For further information on Minnesota's Medicaid regulations:

- **Recipient Payment for Noncovered Prescriptions**
- **Pharmacy Services**

If you have questions regarding claims processing, please call Prime's Contact Center at **844.765.5940**.

For further information on Minnesota's Medicaid regulations, visit **Minnesota Department of Human Services**.

SECTION 7: MEDICAID REQUIREMENTS (CONTINUED)

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 participating 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, a 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
- Pharmacy Disclosure Statement

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. Prime uses the [Texas State Board of Pharmacy website](#) as the primary source of validation to verify that all pharmacies and pharmacists’ licenses 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 Participating 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 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, 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

SECTION 7: MEDICAID REQUIREMENTS (CONTINUED)

- › 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 and/or the FDA, and 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 nonsterile 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 also considers the following additional to be 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.

SECTION 7: MEDICAID REQUIREMENTS (CONTINUED)

- 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 as follows:

- STAR Covered Persons at **855.457.0405**
- CHIP Covered Persons at **855.457.0403**
- STAR Kids (in the Travis service area) at **855.457.0757**
- STAR Kids (in the MRSA Central service area) at **855.457.0758**

Maximum Allowable Cost (MAC) and Appeals

To place a drug 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. The drug must also:

- Have an "NR" or "NA" rating or a similar rating by a nationally recognized reference.
- Be generally available for purchase by Participating Pharmacies in the state of Texas from national or regional wholesalers.
- Not be obsolete.

Prime's MAC pricing is reviewed a minimum of once every seven days. This ensures that the MAC price of every drug is based on the current market price of available therapeutically equivalent drugs. A Participating Pharmacy 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 Participating Pharmacies as determined by Prime. If the challenge is denied, Prime will provide a reason for the denial.

If a Participating Pharmacy would like access to Prime's MAC lists, 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 lists.

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 and 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 as follows:

- STAR Covered Persons at **855.457.0405**
- CHIP Covered Persons at **855.457.0403**
- STAR Kids (in the Travis service area) at **855.457.0757**
- STAR Kids (in the MRSA Central service area) at **855.457.0758**

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. The 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, the Participating Pharmacy may contact Prime's Contact Center as follows:

- STAR Covered Persons at **855.457.0405**
- CHIP/CHIP Covered Persons at **855.457.0403**
- STAR Kids (in the Travis service area) at **855.457.0757**
- STAR Kids (in the MRSA Central service area) at **855.457.0758**
- **CoverMyMeds**

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 **855.457.0407** to initiate a PA request.

If the Participating Pharmacy is unable to override, simply call Prime's Contact Center—available 24 hours/7 days a week—for assistance:

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

- STAR Kids (in the Travis service area) Pharmacy Contact Center at **855.457.0757**
- STAR Kids (in the MRSA Central service area) Pharmacy Contact Center at **855.457.0758**

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 (PA Type Code) and code "801" in field 462 EV (PA 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. However, it does not apply to hepatitis C drugs or any drug not considered to be an emergency in the judgment of the dispensing pharmacist.

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 and where delay could cause harm. If the Prescriber cannot be reached or is unable to request a PA, the Participating Pharmacy should submit an emergency 72-hour prescription.

SECTION 7: MEDICAID REQUIREMENTS (CONTINUED)

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-days' supply of medication. This program defines a standard 34-days' supply of medication for a select list of medications. If a medical condition warrants a greater quantity supply than the defined 34-days' 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.

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 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 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
- OTC 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 contact Prime's Contact Center as follows:

- STAR Covered Persons at **855.457.0405**
- CHIP Covered Persons at **855.457.0403**
- STAR Kids (in the Travis service area) at **855.457.0757**
- STAR Kids (in the MRSA Central service area) at **855.457.0758**

Retail pharmacies can dispense no more than a 34-days' 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 **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

Member Type	Copay for up to 34-day supply
STAR	No copay
CHIP < 100% FPL	\$0 for generic/\$3 for brand
CHIP 101 – 150% FPL	\$0 for generic/\$5 for brand
CHIP 151 – 185% FPL	\$10 for generic/\$35 for brand
CHIP 186 – 200% FPL	\$10 for generic/\$35 for brand
CHIP Perinate	No copay
CHIP AIAN	No copay
CHIP No Cost Share	No copay

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](#).

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) is 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.

Non-covered Services

If Participating Pharmacy receives a non-covered Prescription Drug Services for a Covered Person, Participating Pharmacy must inform the Covered Person of the cost and obtain a signed private pay form from the Covered Person prior to rendering the services. The private pay form may be found in the TMHP Provider Enrollment and Responsibilities.

Delivery Service

If Participating Pharmacy elects to provide delivery services to Covered Persons under the Texas Medicaid Network, Participating Pharmacy may not charge the Covered Person for a delivery fee. Pharmacy must adhere to the State's delivery incentive requirements found on the Pharmacy Provider Enrollment Application. If Pharmacy is in violation of this requirement, Prime, Benefit Sponsor or HHSC reserves the right to terminate Participating Pharmacy from the Texas Medicaid Network.

Covered Person Protections

If Participating Pharmacy is aware of any reports to authorities on abuse, neglect, or exploitation of a Covered Person, Participating Pharmacy must notify Prime of any such reports including but not limited to Participating Pharmacy self-reports and reports made by others.

SECTION 7: MEDICAID REQUIREMENTS (CONTINUED)

Durable Medical Equipment

If Participating Pharmacy processes or intends to process a durable medical equipment (DME) prescription, Prime encourages Participating Pharmacy to become Medicaid-enrolled as a DME provider. Please refer to the State of Texas' Vendor Drug Program ("VDP") to request for a DME application. To be listed as a DME provider, a pharmacy must be a VDP pharmacy and attested with Texas Medicaid and Healthcare Partnership ("TMHP").

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**
- BCBSTX STAR Kids (Travis service area): **855.457.0757**
- BCBSTX STAR Kids (MRSA Central service area): **855.457.0758**

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

- BCBSTX CHIP: **855.457.0403**
- BCBSTX STAR: **855.457.0405**
- BCBSTX STAR Kids (Travis service area): **855.457.0757**
- BCBSTX STAR Kids (MRSA Central service area): **855.457.0758**
- Pharmacy prior authorization fax: **877.243.6930**

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