



OptumRx

2016 provider manual (PM)



Introduction



A. About this provider manual (PM)

The Administrator Provider Manual (PM), also known as “Provider Manual”, includes the policies and procedures for pharmacies, pharmacists, as well as pharmacy staff (*collectively, Network Pharmacy Providers*) which serve Members pursuant to the Administrator’s, Catamaran’s and its affiliates participating pharmacy provider network agreements, including, but not limited to the Pharmacy Network Agreement, Specialty Pharmacy Network Agreement and Provider Agreement.

Administrator appreciates your participation in its pharmacy network and your role in delivering quality Covered Prescription Services to our Members. The PM is incorporated into and is a part of your Agreement. As a Network Pharmacy Provider, you are responsible for monitoring and complying with all changes to the PM. Failure to adhere to any of the provisions and terms of the Agreement, which includes this PM, as well as all other applicable documents, will be viewed as a breach of the Agreement.

Please Note:

Network Pharmacy Providers’ participation in an Administrator or Client network shall not guarantee participation in all networks. Administrator reserves the right to limit Network Pharmacy Providers (and any of its pharmacies’) participation in a network in its sole discretion.

Any Agreement entered into by-and-between Administrator and Network Pharmacy Provider will have an effective date executed by Administrator (“Effective Date”); shall continue uninterrupted until terminated by either party according to the terms and conditions of the Agreement.

Network Pharmacy Provider understands Administrator is relying on its participation in applicable networks and as such shall not be allowed to opt-out of any networks without the written consent of Administrator.

- Information in this PM is current at the time of publication.
 - While efforts are made to keep the information current, this PM is subject to change without notice.
- This PM is not designed to cover all circumstances or issues, nor is it a replacement for sound clinical judgment.
- Online Claim adjudication via the Point-of-Sale (POS) System will reflect the most current benefit and takes precedence over printed information.
- For your convenience, all capitalized terms contained in this PM will have the meanings as set forth in the Agreement or are listed and defined in this PM.
- In the event this PM and the Agreement have conflicting language, the PM will supersede the Agreement.
- For specific details regarding the particular terms and conditions of the contract between Administrator and its participating pharmacies, please refer to the Agreement.
 - Administrator intends for this PM to provide information as to adequately address questions and concerns related to the Administrator pharmacy program. Please contact the Administrator for additional questions.
- All Administrator fax blast communications (e.g. Faxblast Communication), sent prior and after participation as a Network Pharmacy Provider are hereby incorporated by reference into both the PM and Agreement.

B. Images used in the PM



Friendly FYI for our valued Network Pharmacy Providers



Looking out for our valued Network Pharmacy Providers



Helpful examples & encouragement to reach out for additional assistance (please see Section II)



Notable information for routine use by Network Pharmacy Providers

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I. Definitions



The following terms are used throughout this document and are derived from the Agreement, CMS regulations and other program documents:

Administrator:

OptumRx, Inc., OptumRx NY IPA, Inc., OptumRx, LLC and any subsidiaries or affiliates which provide pharmacy benefit services, including, but not limited to, Catamaran, LLC.

Agreement:

Administrator's, Catamaran's and its affiliates participating pharmacy provider network agreements, including, but not limited to the Pharmacy Network Agreement, Specialty Pharmacy Network Agreement and Provider Agreement.

Average Wholesale Price (AWP):

AWP and brand or generic Prescription classification is determined by Administrator in all cases and updated at least weekly. Administrator shall use Client or Benefit Plan, Medi-Span or other national resource and internal processes as a reference, but not as the sole determinant. WAC-referenced based pricing may be implemented should AWP become obsolete or if Benefit Plan or market conditions warrant such pricing methodology. Other nationally recognized referenced based price sources may also be implemented as market conditions warrant or under the circumstances where AWP becomes obsolete.

Benefit Plan:

Benefit or Plan provided to Clients' Members, including but not limited to under any Commercial, Medicaid, Medicare, MA-PD Plan or Prescription Drug Plan. Benefit Plan coverage shall include, without limitation, any deductible or coverage gap provided for under such coverage, without regard to any subsidy by any third party of a Member's Cost-Sharing obligations under the applicable Benefit Plan. Benefit Plan may also include coverage for workers compensation, hospice and discount card programs.

Benefit Plan Sponsor:

Any person, Client or entity, including government agencies, which has entered into, or in the future enters into, a written Agreement with Administrator or a Client pursuant to which Administrator provides certain consultative, administrative, and/or Claims processing services in connection with the operation of one or more Benefit Plans sponsored, issued or administered by such person, Client or entity and/or that person's, Client's or entity's customer.

Brand Name Drug:

Drug Product marketed under a proprietary and trademark-protected name.

Centers for Medicare and Medicaid Services (CMS):

CMS is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in LTC facilities (more commonly referred to as nursing homes) through its survey and certification process.

Claim:

Network Pharmacy Provider's billing or invoice for a single Prescription for Covered Prescription Services dispensed to a Member submitted by Network Pharmacy Provider to Administrator or claims processor in accordance with the Agreement. If a Claim is not processed in accordance with the Medicaid or Medicare Part D Addendum, Amendment, Exhibit, such Claim is considered a commercial Claim.

Claims Processor:

Claims Processor Administrator or a third party pharmacy claims processor with which Administrator may contract.

Clean Claim:

Prepared in accordance with the standard formats promulgated by the National Council for Prescription Drug Programs, electronic, batch, and on paper, which contains all of the information necessary for processing (including, without limitation, the Member identification number, the Member's name and date of birth, Drug Product NDC number, drug quantity, days' supply, health care provider Drug Enforcement Administration (DEA)/National Provider Identification (NPI) number, Pharmacy National Council for the Prescription Drug Programs (NCPDP)/NPI number, date of service, Submitted Cost Amount and the U&C). Claims submitted in non-NCPDP standard format will not be considered a Clean Claim and will be subject to an additional Claim processing charge. A Claim shall not be considered a "Clean Claim" if at Administrator's sole discretion it determines that such Claim is (i) discrepant, false and/or fraudulent, (ii) by an individual not authorized under applicable law or regulation to write or direct the related Prescription, or (iii) with respect to any Benefit Plan that is a "Federal health care program" as defined in 42 U.S.C. 1320a-7b, relates to a Prescription written or directed by an individual who is excluded from participation in any Federal health care program pursuant to applicable federal/state law (*individually and collectively, a Non-Clean Claim*). In addition and as determined by Administrator's sole discretion, a Non-Clean Claim includes a Claim for a Drug Product that was Mailed, shipped or delivered by a Pharmacy that does not participate in Administrator's Mail Order Pharmacy Network pursuant to a mutually signed Mail Order Pharmacy Network Agreement. An Administrator's Non-Clean Claim determination shall be applicable regardless of whether Administrator, Client, Member, and/or Pharmacy were aware of the same at the time such Prescription was processed by Pharmacy. Any amounts paid by any Member, Administrator or Client for such Non-Clean Claim shall be subject to recoupment from Pharmacy by Administrator.

Client:

Any person or entity which has entered into, or in the future enters into, a written Agreement with Administrator pursuant to which Administrator provides certain consultative, administrative and/or Claims processing services in connection with the operation of one or more Benefit Plan Sponsored, issued or administered by such person or entity and/or that person's or entity's customer including, but not be limited to health maintenance organizations, preferred provider organizations, limited service health organizations, medical service plans, other managed care plans, third party administrators, union trusts, insurance companies/carriers, self-insured groups, workers' compensation carriers/administrators, discount plans/programs, health coalitions, health exchanges, managed Medicaid plans, other health-related entities and/or plans.

Compounded Drug:

A combination mixture or alteration of a Federal Legend Drug in which a Network Pharmacy Provider combines, mixes, alters solid, semisolid or liquid ingredients, at least one of which is a Covered Prescription Service weighed or measured and prepared according to the Prescriber's order and the Pharmacist's art to create a medication tailored to the needs of a Member which is not a commercially available Drug Product. This excludes any flavoring, sweetener, dilution and reconstitution of a Drug Product (e.g. an oral antibiotic) according to manufacturer guidelines.

Coordination of Benefits (COB):

Provision in a contract that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over-insurance or duplication of benefits.

Cost-Sharing or Cost-Sharing Amounts:

Administrator shall communicate to Network Pharmacy Provider (via the POS System) the Cost-Sharing Amounts (e.g. Co-payment and Deductible) applicable to Covered Prescription Services. Unless otherwise required under the Agreement, Pharmacy shall collect the full Cost-Sharing Amounts (if any) from the Member that are applicable to

Covered Prescription Services being dispensed to Members. Pharmacy shall not at any time seek reimbursement for Cost-Sharing Amounts from Administrator or any Client. "Co-payment" or "Deductible" means a fixed dollar or a percentage portion of the charge for the Drug Product being dispensed by Network Pharmacy Provider to Member which is to be paid by Member.

Covered Prescription Service or Services:

Prescriptions and other pharmaceutical products, services and supplies dispensed by a Pharmacy to a Member for which coverage is provided pursuant to the terms and conditions of the Benefit Plan.

Drug Product:

Brand Name Drug or Generic Drug which is (i) required under applicable laws and regulations to be dispensed only pursuant to a Prescription and (ii) is approved by the FDA unless exempt from such approval requirements by the FD&C Act of 1962.

Faxblast Communications:

Sent electronically to the contracted network entity (i.e. independent pharmacy, retail chain, PSAO corporate representative) via facsimile (i.e. fax) process or email, which include from time to time general announcements, Provider Manual updates and Pharmacy Plan Specifications.

First-tier, Down-stream or Related Entity (FDR):

CMS reference to the various contractual relationships that an entity may have with a MA, MAPD, MMP or PDP Sponsor for delegated sponsor services.

Formulary:

A set of Drug Products and their associated coverage information (e.g. tiers, restrictions, limits and coverage exclusions).

Formulary and Generic Drug:

In the provision of Covered Prescription Services, all Network Pharmacy Providers shall use its best efforts, in accordance with all applicable federal/state laws, to adhere to and promote the Formulary, except to the extent the Network Pharmacy Provider is: (i) prohibited by state law or (ii) otherwise directed by Administrator through the POS System. If (i) neither the Prescription nor applicable federal/state laws prohibit substitution of a generic drug equivalent for the Drug Product and (ii) Network Pharmacy Provider obtains consent from the Member, as well as the Member's physician, when and if required by applicable federal/state laws, then Network Pharmacy Provider shall dispense a generic drug equivalent for the Drug Product to the Member.

Fraud, Waste and Abuse (FWA):

Fraud

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 United States Code §1347).

Waste

Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse

Actions that may, directly or indirectly, result in: unnecessary costs to the Medicare and Medicaid Programs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse

cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Generic Drug:

Identified by its chemical, proprietary or nonproprietary name, which is accepted by the FDA as therapeutically equivalent to an originator Brand Name Drug unless exempt from such approval requirements by the FD&C Act of 1962.

Gramm-Leach-Bliley (GLB):

The Financial Modernization Act of 1999 also known as the Gramm-Leach-Bliley Act (codified at 15 USC § 6801 et seq.); together with any rules and regulations from time to time promulgated thereunder, as may be amended, modified, revised, replaced, interpreted by any Governmental Authority or court.

Government Authority:

Including, but not limited to the federal government, any state, county, municipal, local government, any governmental department, political subdivision, agency, bureau, commission, authority, body, instrumentality or court, which might regulate the activities/operations of either party, parties’ Affiliate or Client.

Health and Human Services (HHS):

The United States (U.S.) Department of Health and Human Services or any successor Government Authority.

Health Insurance Portability and Accountability Act (HIPAA):

The Health Insurance Portability and Accountability Act of 1996; the rules and regulations adopted by HHS pursuant to HIPAA, including the Standards for Privacy of Individually Identifiable Health Information, as well as the Security Standards for the Protection of Electronic Protected Health Information, 45 CFR parts 160 and 164 (subparts A, C, and E) as each may be amended, modified, revised, replaced, interpreted by any Government Authority or court.

Home Infusion (HI) Pharmacy:

Pharmacy-based, decentralized patient care organization with expertise in USP 797-compliant sterile compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional Prescriptions administered through catheters and/or needles in home and alternate sites. Pharmacies must have a ‘clean room’ and ‘hood’ in order to provide sterile compounding of Infusion Therapy Covered Prescription Services.

Infusion Therapy:

Involves the administration of medication through a needle or catheter and it is prescribed when a Member’s condition is so severe that it cannot be treated effectively by oral medications. Typically, “infusion therapy” means a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes (e.g. intramuscular injections and epidural routes; into the membranes surrounding the spinal cord). “Traditional” Prescription drug therapies commonly administered via infusion include antibiotic, anti-fungal, antiviral, chemotherapy, hydration, pain management and parenteral nutrition.

Long-term-care (LTC) Facility:

Facility as defined under 42 CFR § 423.100, as amended from time to time; does not include non-institutionalized living arrangements and/or facilities such as assisted living facilities or other senior housing or senior care facilities.

Long-term-care (LTC) Pharmacy:

A Pharmacy provides Drug Products to LTC facilities. For Medicare Part D, Network Pharmacy Provider provides Drug Products to LTC Facilities when the Claims are submitted by a Network Pharmacy Provider which meets the definition of a “long-term-care network pharmacy” under 42 CFR §423.100, as amended from time to time for a Medicare Drug Plan Member residing in a Long-Term-Care Facility.

Mailing/Mail:

Action or process of sending Covered Prescription Services through the US mail, shipping via any common carrier (e.g. FedEx, UPS, DHL) or via delivery by any type of courier to Members.

Mail Order Pharmacy:

Pharmacies where Drug Products are prepared, dispensed and sold, including Covered Prescription Services, to Members and delivered via Mailing. These pharmacies typically do not offer walk-in services to our Members. Mail Order Pharmacies are responsible for ensuring proper prescription shipment/delivery in alignment with federal/state-level regulations and licenses. Mail Order Pharmacies are not Retail Pharmacies for the purposes of the retail Agreement.

Marks:

Name(s), logo(s) and other proprietary symbols/phrases belonging to an entity.

Maximum Allowable Cost (MAC):

MAC for pharmaceutical products is developed by Administrator based upon information provided by Medi-Span or any other nationally recognized pricing source selected by Administrator and may be amended from time-to-time at its sole discretion in accordance with applicable law.

- Administrator determines MAC pricing based on a review of the following: pricing information from a nationally recognized pricing service, one or more national drug wholesalers and/or manufacturers, and the publicly available results of CMS' survey of retail prices. Administrator reserves the right to update its MAC pricing methodology and to use alternative, reputable sources at its discretion. Upon written request and to the extent required by law, Administrator will make available the current and applicable MAC price information to Network Pharmacy Provider. Such MAC price lists constitute confidential information.

Medicare Advantage Prescription Drug Plan (MA-PD):

CMS-approved MA-PD plans sponsored, issued or administered by Clients as defined in 42 Code of Federal Regulations (CFR) §423.4, and includes, but is not limited to, private fee-for-service plans as defined in the Medicare Advantage rules and any CMS demonstration programs that provide Prescription Drug Product benefits. For purposes of this Agreement, "MAPD Plan" also includes any employer-sponsored MA-PD plan referenced in 42 CFR §422.106.

Medicare-Medicaid Enrollees (MME):

Members are dually eligible in both Medicare and Medicaid.

Medicare-Medicaid Plans (MMPs):

A new product developed by the Centers for Medicare and Medicaid Services (CMS) and the states for managing the health benefits of Medicare – Medicaid Enrollees (MMEs). It is a system of managed care plans selected to coordinate the physical, behavioral and LTC services for individuals over the age of 18 years who are eligible for both Medicare and Medicaid benefits. This includes people with disabilities, older adults and individuals who receive behavioral health services. Rather than have benefits covered under two different products, MMPs provide a combined benefit package, in which all benefits available through Medicare and Medicaid are integrated. The MMPs may vary slightly from state to state, depending on how the state defines their portion of the benefit package. From a pharmacy benefit perspective, the Medicare and Medicaid benefits are integrated and managed as a single Benefit Plan.

Medicare Part D Sponsor:

Any person, Benefit Plan Sponsor, Client or entity which has entered into, or in the future enters into, a written Agreement with CMS to offer PDP and/or MA-PD Plans pursuant to which Administrator provides certain consultative, administrative, and/or Claims processing services in connection with the operation of one or more PDP and/or MA-PD Plans sponsored, issued or administered by such person, Benefit Plan Sponsor, Client, or entity and/or that person's, Client's, Benefit Plan Sponsor's or entity's customer.

Member:

Individual, including a dependent or pet, who is eligible and/or enrolled to receive coverage through a Benefit Plan from a Client for Covered Prescription Services.

National Average Drug Acquisition Cost (NADAC):

NADAC of Drug Products or ancillary supplies, as applicable, as dispensed and as set forth in the latest edition of the Medi-Span® Prescription Pricing Guide (with supplements) or any other nationally recognized pricing source selected by Administrator (the "Pricing Source"), as updated at least monthly.

National Council of Prescription Drug Programs (NCPDP):

The National Council of Prescription Drug Programs.

National Provider Identification (NPI) number:

Unique ten (10) digit identifier assigned to health care providers to use when submitting a HIPAA standard transaction.

Original Document of Record:

An original Prescription order from a Prescriber, or duly authorized health care professional, executed as required under State and Federal laws, a fully compliant fax order, or fully compliant phone-in order slip reduced to writing and noting the date and time of the phone order and the name of the individual authorizing the Drug Product, or a fully compliant e-Prescription.

Pharmacist:

An individual appropriately licensed in their respective States to dispense and sometimes prescribe Drug Products to Members.

Pharmacy/Network Pharmacy Provider:

Entity that is contracted directly as a chain or independent pharmacy with Administrator or indirectly contracted through a Pharmacy Services Administration Organization (PSAO) or *Group Purchasing Organization (collectively, 'PSAO')* or chain to provide Covered Prescription Services to Administrator Clients' Members, in accordance with the Agreement, addenda, exhibits, Plan Specifications, subsequent amendments, etc., and as specified in the Agreement.

Pharmacy Plan Specifications:

Information made available by Administrator to assist Network Pharmacy Provider in submitting a Claim for Covered Prescription Services.

Pharmacy Services Administration Organization (PSAO):

An organization that represents and serves as the agent of Pharmacies and contracts with Administrator on behalf of their own network of pharmacies. A PSAO may also be a *Group Purchasing Organization*.

Point-of-Sale (POS) System:

The online or real-time POS telecommunication system used to communicate information including, but not limited to Claims for Covered Prescription Services to Administrator, claims processor or Catamaran system.

Prescriber:

An individual appropriately licensed in their respective States to write Prescriptions for Members.

Prescription:

A written, oral or electronic order to dispense a Drug Product directed by an appropriately licensed, as well as qualified health care professional in accordance with federal and/or state law.

Prescription Drug Compensation:

POS System transaction response reimbursement per Claim prevails, unless overpayment is made to Network Pharmacy Provider. Administrator may modify Prescription Drug Compensation of any Compensation Exhibit upon notice to Network Pharmacy Provider.

Prescription Drug Contracted Rate:

The meaning set forth in the applicable Compensation Exhibit(s), attached to the Agreement.

Prescription Drug Plan (PDP):

CMS approved Medicare Part D Prescription Drug Product coverage offered under a policy, contract or plan that is sponsored, issued or administered by Clients pursuant to a contract with CMS, as defined in 42 CFR §423.4, and includes, but is not limited to, any CMS demonstration programs that provide Prescription Drug Product benefits. For purposes of the Agreement, PDP also includes any employer-sponsored group Prescription drug plans, as defined in 42 CFR §423.454.

Prior Authorization (PA):

Request initiated via fax, phone or online submission by the Member, Prescriber, or Member's appointed representative to review non-formulary Drug Products utilizing clinical guidelines. Network Pharmacy Providers may not act in the capacity of a Prescriber without an appointment of representation. Member information, diagnosis, justification for using Drug Product not covered under the individual's Benefit Plan and other pertinent information are reviewed to determine exception.

Records:

All books, records, documentation, data files, accounts, drug purchase invoices and pedigrees, signature logs of all Transactions including, but not limited to the Prescription information or Original Document of Record required to validate the accuracy, completeness of the purchase of the Drug Product, dispensing of the Prescription for a Covered Prescription Service to the Member, submission of the Claim, verification of the pharmacy, pharmacist, pharmacy technician licenses and credentials.

Retail Pharmacy:

Any facility licensed by and pursuant to laws and regulations of the State of residence and by any other state in which the pharmacy provides services and drugs. The facility may be a store, clinic, or part of a store, clinic or hospital in which Drug Products are prepared, dispensed and sold, including Covered Prescription Services provided to Members as walk-in customers or a pharmacy providing services to skilled nursing facilities licensed by the state of residence as a retail pharmacy. A pharmacy may be considered for retail participation even if closed-door (e.g. a clinic/hospital pharmacy or government institution).

- A retail pharmacy does not i) deliver Drug Products via Mailing, ii) advertise itself as a Mail Order Pharmacy for obtaining Prescriptions delivered through Mailing, nor iii) self identifies with NCPDP as any of the following: Mail Order Pharmacy (dispenser type code "5") or Specialty Pharmacy (dispenser type code of "15")

Safety Net Pharmacy:

A 340B Participating Pharmacy by mandate or mission organizes and delivers a significant level of Covered Prescription Services, including but not limited to the uninsured, Medicare, Medicaid and other vulnerable populations.

Specialty Drugs:

Includes biotechnology products, orphan Drug Products used to treat rare diseases, typically high-cost Drug Products, including infusions in any outpatient setting, Drug Products requiring ongoing frequent management/monitoring of the patient by clinician or Drug Products used to treat chronic and potentially life-threatening diseases.

Specialty Pharmacy:

A specialty pharmacy is a specific type of pharmaceutical delivery system which coordinates delivery and offers comprehensive support in the distribution of Specialty Drugs. Specialty pharmacies are distinct from traditional pharmacies in coordinating many aspects of Member care and disease management. They are designed to efficiently deliver medications with special handling, storage and distribution requirements with standardized processes. Specialty pharmacies are also designed to improve clinical and economic outcomes for Members with complex, often chronic and rare conditions, with close contact and management by a clinician.

Submitted Cost Amount:

Submitted ingredient costs, dispensing fees and all other submitted costs incurred by a Pharmacy for dispensing of a Drug Product, device, product and/or supply.

Transaction:

Any transaction or Claim submitted by Network Pharmacy Provider to the claims processor whether it is incomplete, rejected, paid, a reversal, reversal reject, reversal due to Claim adjustment or duplicate transaction.

Usual and Customary (U&C):

Price charged by Network Pharmacy Provider to the general public at the time of dispensing for the same Drug Product including all applicable customer discounts, such as advertised or sale prices, special customer, senior citizen, frequent shopper, coupons or other discounts, a cash paying customer pays Network Pharmacy Provider for Drug Products, devices, products and/or supplies. Network Pharmacy Provider must supply proof of a cash Prescription (i.e. without any disclosure of PHI) when necessary to evaluate the appropriate adjudication of the Transaction. Alteration of the U&C price to attempt to increase Claim payment without a true change to the cash price being offered to the general public will be considered non-compliance and a violation of the Agreement. The Network Pharmacy Provider must be able to communicate the U&C price to Administrator upon inquiry, failure to disclose this information will be considered non-compliance.

Universal Claim Form (UCF):

NCPDP standardized Claim form used by Network Pharmacy Provider for manual billing.

Wholesale Acquisition Cost (WAC):

Shall mean the average wholesaler acquisition cost of a Covered Prescription Service based on the Medi-Span® Prescription Pricing Guide (with supplements) or any other nationally recognized pricing source selected by Administrator (the "Pricing Source"), as updated at least weekly.

340B Drug Pricing Program:

Federal drug discount program established under Section 340B of the Public Health Service Act.

340B Participating Entity:

Healthcare organization eligible to access the 340B Drug Pricing Program to purchase Drug Products for itself or contracted pharmacies.

340B Participating Pharmacy:

Network Pharmacy Provider contracted to access the 340B Drug Pricing Program via a 340B Participating Entity, by Drug Products purchase or replacement, for eligible Members.

II. Contact information



Administrator strives to ensure that pharmacies receive prompt and courteous attention when questions arise. For assistance in processing a Claim or questions concerning Administrator pharmacy programs, **please contact the Administrator at the telephone number identified on the Member's identification (ID) card** or contact the Administrator as indicated below. Hours of operation may change during holidays.

Please Note:

With the integration of OptumRx and Catamaran information may be specific to a legacy entity at this time. Please refer to the BIN/PCN information to determine which specific contact information to use.

A. Pharmacy help desk service contact information



Hours of operation: 24 hours a day, 7 days a week, 365 days a year

For Member information regarding Benefit Plan **exclusions, disease therapy management (DTM) programs or other customer service issues**, please contact us using one of the following:

For Plans not listed under Appendix:

- For all other plans, use the Pharmacist number on the Member's ID card.
- Telephone Device for the Hearing Impaired (TDHI): **1-866-498-5428**

Catamaran pharmacy help desk:

- Telephone: **1-800-880-1188**

Website for health care professionals:

- **Optumrx.com**
- **Catamaranrx.com/pharmacies**

B. Prior authorization (PA) service contact information



OptumRx — Hours of operation: Monday–Friday, 5 a.m. to 10 p.m. (Pacific Time);
Saturday, 6 a.m. to 3 p.m. (Pacific Time)

Catamaran — Hours of operation: 24 hours per day, 7 days a week, 365 days per year

For Member information regarding **utilization management requirement, Medicare Part D decisions, coverage limitations and PAs**, please contact us using one of the following:

OptumRx

- Telephone: **1-800-711-4555**
- Telephone (Innoviant): **1-866-565-7723**
- Fax (Oral): 1-800-527-0531
- Fax (Specialty): 1-800-853-3844

Catamaran

- Telephone: **1-800-626-0072**
- Fax (Oral): 1-866-511-2202

C. Pharmacy network contracting department contact information:

 Hours of operation: Monday–Friday, 8 a.m. to 5 p.m. (Pacific Time)

To request a contract or questions related to contracting, please contact us using one of the following:

Pharmacy Network Contracting Department

17900 Von Karman
(MS: CA016-0200)
Irvine, CA 92614

- Telephone: **1-800-613-3591**
- Fax: 1-866-811-4224
- Email address: **pharmacycontracts@optum.com**

To enroll as a Network Pharmacy Provider to participate in a Catamaran or Catamaran plan-sponsored network, call the Catamaran Pharmacy Network Contracting Department and request the enrollment forms or follow the directions under Agreement via the link below:

Catamaran Pharmacy Network Contracting Department

- Telephone: **1-877-633-4701**
- Web address: **catamaranrx.com/pharmacies**
- Email: **provider.relations@optum.com**

D. MAC appeals contact information:

To review the summary and guidelines for appealing MAC prices/pharmacy reimbursement, as well as downloading the form for submitting appeals, please follow the applicable link:

OptumRx

- <https://optumrx.com/RxsolHcpWeb/cmsContent.do?pageUrl=/HCP/HealthcareProviderTools/FormsAndDocuments>

 OptumRx — Hours of operation: Monday–Friday, 8 a.m. to 5 p.m. (Pacific Time)
Catamaran — Hours of operation: Monday–Friday, 8 a.m. to 5 p.m. (Central Time)

OptumRx

- Telephone: **1-800-613-3591 Ext. 9**
- Email address: **rxreimbursement@optum.com**

Catamaran

- Web address: **catamaranrx.com/pharmacies**

E. Pharmacy network credentialing department contact information:

 Hours of operation: Monday–Friday, 8 a.m. to 5 p.m. (Pacific Time)

For initial independent retail pharmacy credentialing application, credentialing application status and questions related to credentialing, please contact us using one of the following:

Pharmacy Network Credentialing Department

17900 Von Karman
(MS: CA016-0200)
Irvine, CA 92614

- Telephone: **1-800-613-3591**
- Fax: 1-877-593-5368
- Email address: **pharmacycredentialing@optum.com**

F. Provider forms and documents contact information

To submit forms online, mail or fax requests regarding the *PA Guidelines and/or Formulary change request form(s)*, please contact us using one of the following:

Provider forms and documents available online:

- <https://optumrx.com/RxsolHcpWeb/cmsContent.do?pageUrl=/HCP/HealthcareProviderTools/FormsAndDocuments>



Administrator is unable to accept incomplete Provider forms and documents. In order to avoid a delay in processing your request, please complete these forms in their entirety.

- catamaranrx.com/pharmacies (access to the portal will require proper credentials).



It is important to refer to this web-portal for current documents, forms, manuals, payer sheets and other communications.

Prior authorization (PA) guideline change request form via mail or fax:

OptumRx

Clinical Programs
2300 Main Street, CA 134-0404
Irvine, CA 92614
• Fax: 1-949-474-4237

Catamaran

Catamaran
P.O. Box 5252
Lisle, IL 60532
• Fax: 1-866-511-2202

Formulary change request form via mail or fax:

OptumRx

Clinical Formulary Operations
2300 Main Street, CA 134-0404
Irvine, CA 92614
• Fax: 1-949-474-4237

Catamaran

Catamaran
P.O. Box 5252
Lisle, IL 60532
• Fax: 1-866-511-2202

G. Faxblast communications

Periodically, Administrator communicates updates to procedures, formularies, PM updates, etc., via Faxblast Communications. They are sent electronically to the contracted entity (Independent pharmacy, Chain, Group Purchasing Organization <GPO> or Pharmacy Services Administrative Organization <PSAO>) corporate office via facsimile (i.e. fax) process or email.

All faxblasts will be made available quarterly and provided in addition to the PM. To request copies of previously sent Faxblast Communications, please contact us using one of the following:

Provider Relations
1600 McConnor Parkway
Schaumburg, IL
60173-6801

- Telephone: **1-877-633-4701**
- Fax: 1-877-339-0784
- Email address: provider.relations@optum.com

III. Member identification (ID) cards

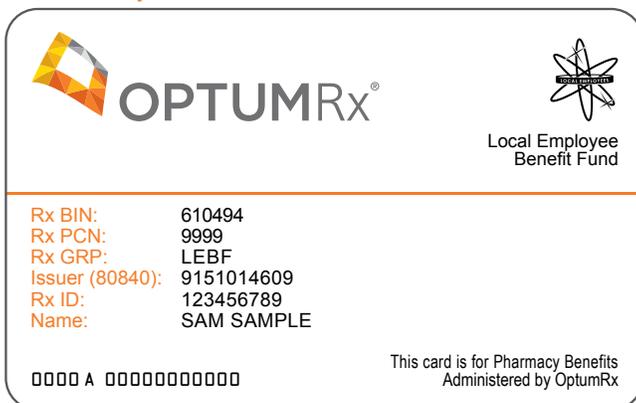


Eligible Members receive an identification (ID) card containing information that helps our Network Pharmacy Providers submit Claims accurately and completely. In accordance with CMS requirements, and/or state regulatory requirements, a Network Pharmacy Provider must submit Claims to the Medicare Part D Sponsor or its intermediary whenever the ID card is presented or on file at the pharmacy, unless the Member expressly requests that a particular Claim not be submitted to the Medicare Part D Sponsor or its intermediary. Information may vary in appearance or location on the card due to employer, Benefit Plan Sponsors or Administrator requirements, however, ID cards display essentially the same information (e.g., Member Name, Subscriber Identification (ID), RxGroup Number (GROUP), Processor Control Number (PCN), Bank Identification Number (BIN), and contact telephone numbers).

The Network Pharmacy Provider shall check the Member's ID card at each visit — especially the first visit of each new benefit year when information is most likely to change. In addition, the Network Pharmacy is responsible for validating the authenticity of Member's identity via government issued photo ID, in alignment with state dispensing requirements.

Below are samples of Member ID cards representing a couple of our Benefit Plan Sponsors. This is a sampling only and is not an all-inclusive list. Member ID cards may be added, deleted or amended at any time. For further information/examples, please see the Appendix.

A. Sample Member ID Cards

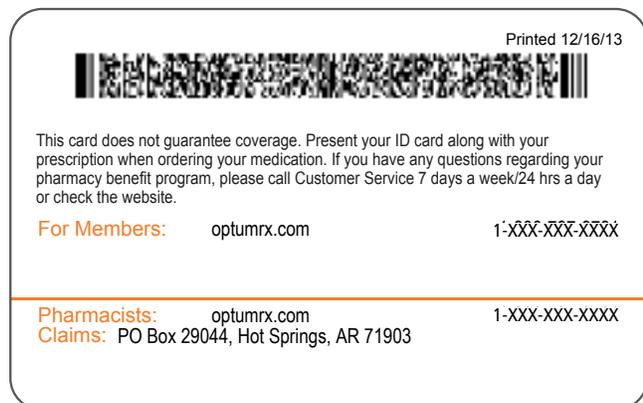


OPTUMRx
Local Employee Benefit Fund

Rx BIN: 610494
Rx PCN: 9999
Rx GRP: LEBF
Issuer (80840): 9151014609
Rx ID: 123456789
Name: SAM SAMPLE

0000 A 000000000000

This card is for Pharmacy Benefits Administered by OptumRx



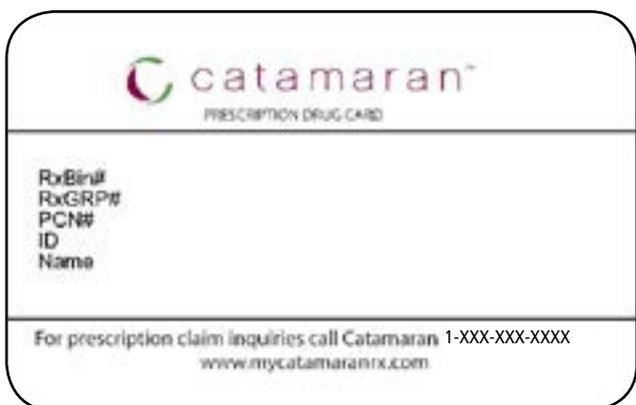
Printed 12/16/13

This card does not guarantee coverage. Present your ID card along with your prescription when ordering your medication. If you have any questions regarding your pharmacy benefit program, please call Customer Service 7 days a week/24 hrs a day or check the website.

For Members: optumrx.com 1-XXX-XXX-XXXX

Pharmacists: optumrx.com 1-XXX-XXX-XXXX
Claims: PO Box 29044, Hot Springs, AR 71903

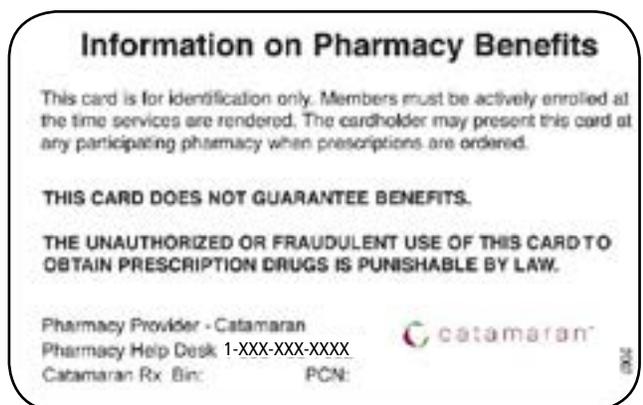
B. Sample Catamaran Member ID Card



catamaran
PRESCRIPTION DRUG CARD

RxBin#
RxGRP#
PCN#
ID
Name

For prescription claim inquiries call Catamaran 1-XXX-XXX-XXXX
www.mycatamaranrx.com



Information on Pharmacy Benefits

This card is for identification only. Members must be actively enrolled at the time services are rendered. The cardholder may present this card at any participating pharmacy when prescriptions are ordered.

THIS CARD DOES NOT GUARANTEE BENEFITS.

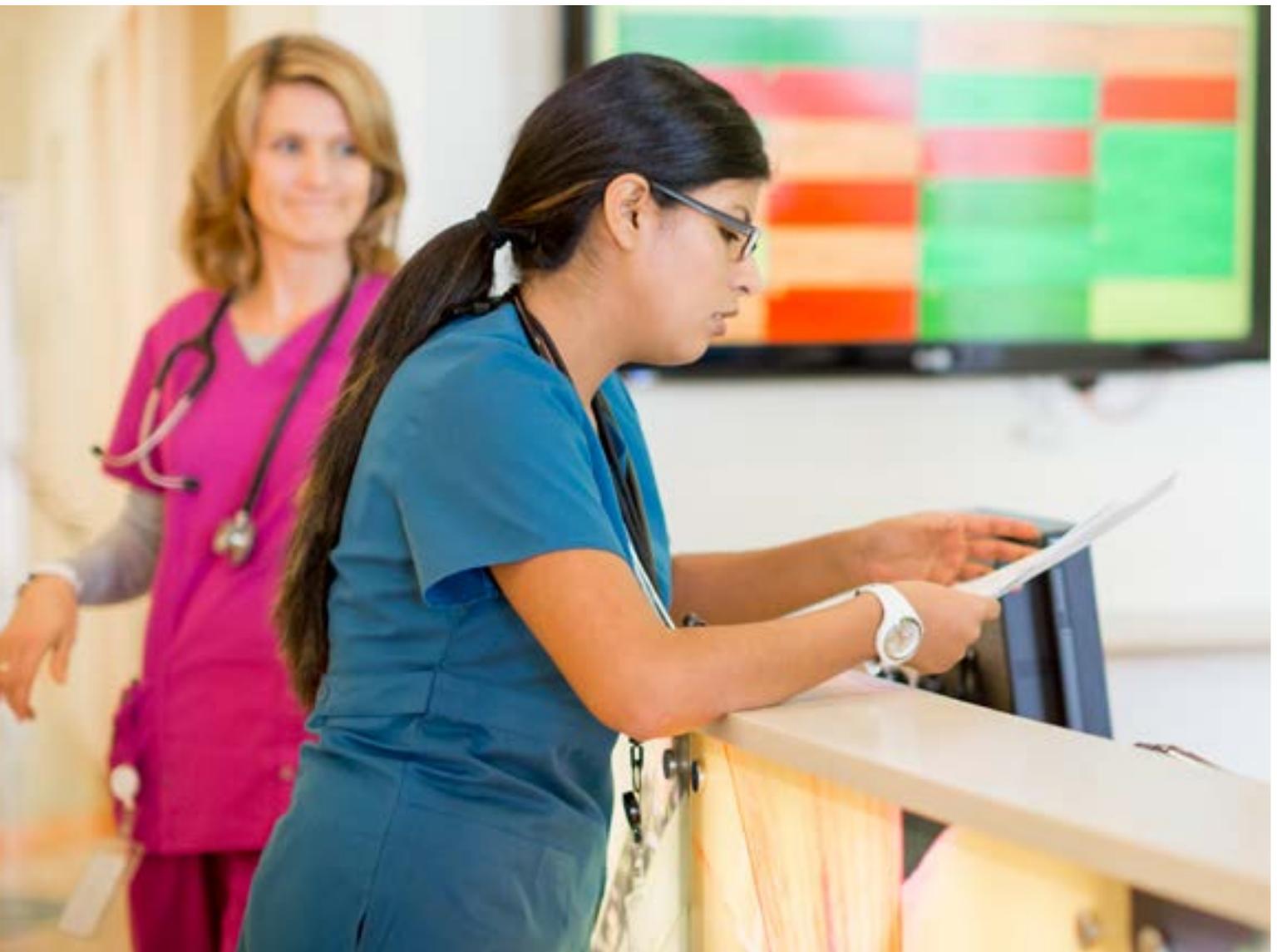
THE UNAUTHORIZED OR FRAUDULENT USE OF THIS CARD TO OBTAIN PRESCRIPTION DRUGS IS PUNISHABLE BY LAW.

Pharmacy Provider - Catamaran
Pharmacy Help Desk 1-XXX-XXX-XXXX
Catamaran Rx Bin: PCN:



This card does not guarantee coverage. If you have any questions regarding Member's pharmacy Benefit Plan, please visit the web address or call the number located on the back of the Member's ID card. The Administrator is open 7 days a week/24 hours a day.

IV. Processing claims



A. General process

The following describes the Administrator processes and procedures for processing Claims.

Complete claims

Administrator requires the submission of a Clean Claim, as described in pharmacy contract Section: *Recitals/Defined Terms*. A Member's level of coverage under his or her Benefit Plan may vary for different services, it is particularly important to correctly code, according to the National Council for Prescription Drug Programs (NCPDP) standards, in order to submit pharmacy Claims for proper payment and application of Cost-Sharing Amounts, COB and other related pharmacy services.

Pharmacies should use best efforts to submit complete and accurate Claims in the POS System or such other method as determined by Administrator. Claims can be reversed up to thirty (30) days after the submission date (or as specified by the Client or Benefit Plan Sponsor); however, when necessary, Claims should be reversed within fourteen (14) days, as soon as reasonably practical or as specified by a particular governing requirement to assure prescriptions with inaccurate information or those not dispensed to Members are credited in a timely fashion. All prescriptions not received by a Member must be reversed within fourteen (14) days from original submission.

Please Note:

Federal programs the Administrator support:

- Federal regulations prohibit the Administrator from paying Claims for Drug Products written by Prescribers which have been excluded from federal program participation as evidenced by listing of the Prescriber within the Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) or General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS) listings.
- These OIG or GSA lists are checked monthly and Claims for Drug Products by excluded Prescriber will be rejected. The Claim will reject with the NCPDP Rejection Code 71 — “MD NOT COVERED — SANCTIONED PRESCRIBER”.
- Claims may only be paid for Prescriptions properly prescribed in accordance with Federal and State prescribing laws and regulations. Please ensure that Network Pharmacy Providers maintain up-to-date knowledge of Federal and State prescribing rules and that pharmacy will not submit a Claim for a Prescription not fully compliant with applicable Federal and State prescribing laws and regulations.

Federal regulations for schedule II drugs

Pursuant to Federal regulations in Title 21 of the CFR § 1306.12(a), Schedule II Drug Products may not be refilled. A separate Prescription is required if a Prescriber wishes to authorize continuation of a patient's use of a Schedule II Drug Products beyond the amount specified on the first Prescription. The regulations at 21 CFR § 1306.13(b) allow for a Prescription for a Schedule II Drug Product written for a patient in a LTC facility or for a patient with a medical diagnosis documenting a terminal illness to be filled in partial quantities to include individual dosage units. Under this provision, a Schedule II Drug Products may be partially filled as long as the total quantity dispensed does not exceed the total quantity prescribed. The regulations at 21 CFR § 1306.13(a) also permit the partial filling of a Prescription for a Schedule II Drug Products if the Pharmacist is unable to supply the full quantity prescribed. The remaining portion of the Prescription may be filled within seventy-two (72) hours of the first partial filling; however, if the remaining portion is not or cannot be filled within the seventy-two (72) hour period, the Pharmacist may not dispense any

further quantity without a new Prescription. According to 21 CFR § 1306.11, except in emergency situations or when dispensed directly by a Prescriber other than a Pharmacist to the ultimate user, Schedule II Prescription Drug Products may not be dispensed without a Prescribers written Prescription. In the case of an emergency situation, a Pharmacist may dispense Schedule II Drug Products upon receiving an oral authorization from a Prescriber, provided that, among other things, the Prescription is immediately reduced to writing by the Pharmacists and contains all information required in 21 CFR §1306.5, except for the signature of the Prescriber.

Online processing window to submit electronic claims

Network Pharmacy Providers are encouraged to submit all Claims at time of dispensing of the Covered Prescription Service or within thirty (30) days.

Commercial Claims:

- Thirty (30) days or such longer period allowed by the Benefit Plan or as required by law or Government Authority. If a Claim is not processed in accordance with the Medicaid or Medicare Part D Addendum Amendment, Exhibit or Schedule, such Claim is considered a commercial Claim.

Medicare Part D Claims:

- One-hundred-eighty (180) days or such longer period as required by law or Government Authority

Medicaid Claims:

- Thirty (30) days or such longer period allowed by the Benefit Plan or as required by law or Government Authority

Please Note:

- Administrator may be unable to extend these time frames.
- Pharmacies that need to process Claim(s) outside the Online Processing Window time frame for submission of Claim(s) via the POS System will be required to submit a Universal Claim Form (UCF) and an explanation for the late submission.
- Submission of the UCF is not a guarantee Claim(s) will be paid.
- Payment is determined on a case-per-case basis upon review of explanation of late submission and Client or Benefit Plan approvals.



In the event a Claim or Transaction rejects at POS, reasonable attempts must be made to retransmit the Claim. In the event the retransmission fails, Network Pharmacy Provider may call the applicable Help Desk contact number for assistance or alternative arrangements to submit the Claim.

Please mail completed UCF and explanation for late submission request to:

OptumRx

P.O. Box 29044
Hot Springs, AR 71903

Catamaran

1600 McConnor Parkway
Schaumburg, IL
60173-6801

National drug code (NDC) number

Network Pharmacy Providers should always submit the eleven (11) or twelve (12) digit NDC number of the actual package size of the Drug Product dispensed in accordance with the applicable payer sheets. Only the NDC of the actual Drug Product dispensed shall be submitted on the Claim transaction. Use of a similar NDC or NDC of a bottle

size not dispensed is not permissible. Invoices and other drug transaction records shall also maintain the exact NDC number, as well as Drug Product name. Invoices, as well as other drug transactions records submitted using incorrect NDC number/Drug Product names are subject to rejection and/or possible reversal.



Do not submit claims for Covered Prescriptions Services using an NDC for a repackaged Drug Product by a repackager. Claims submitted using the repackager's NDC are subject to rejection and/or review and possible reversal.

National provider identification (NPI) number

In compliance with Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the NPI is the required Network Pharmacy Provider and Prescriber ID. The NPI is a unique ten (10) digit identifier assigned to health care providers to use when submitting a HIPAA standard transaction.

Pharmacy ID: Administrator only accepts NPI as the pharmacy identifier for Claims. Any Claims transmitted with a NCPDP or other ID number will be rejected. Although NPI numbers are required for Claims processing, Network Pharmacy Providers are required to maintain a NCPDP ID and regularly update their information with NCPDP.

Prescriber ID: The NPI of the Prescriber is required to be submitted for all Claims. Claims may be rejected without the Prescriber ID; therefore, Network Pharmacy Providers should transmit the Prescriber's NPI whenever it is available. If the Network Pharmacy Providers does not have the Prescriber's NPI on file, the Network Pharmacy Providers should make a reasonable attempt to obtain the NPI number. A Clean Claim requires the submission of the correct Prescriber's ID on all Claims.

In the event that a Claim rejects because the NPI is rejected via the POS System, Network Pharmacy Providers must confirm that the Prescriber NPI is active and correct prior to resubmitting the Claim again via the POS System. Network Pharmacy Providers are expected to resolve NPI issues within 24 hours of initially submitting the Claim to Administrator.

To resolve NPI issues, Network Pharmacy Providers should verify with the Prescriber of the Prescription or check the NPI registry at <https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>



It is up to each Network Pharmacy Providers to ensure that the Prescriber is authorized under applicable law to prescribe the Drug Product prior to submitting the Claim to Administrator. It is not the responsibility of Administrator via the POS System to validate that the Prescriber is authorized under applicable law to write Prescriptions for any particular Drug Product. Claims submitted for Prescriptions written by unauthorized Prescriber are not Clean Claims and may be reversed upon audit by Administrator or a Government Authority in accordance with law.



In order to avoid Claims rejections, please ensure you carefully enter the correct Prescriber Drug Enforcement Administration (DEA) and NPI numbers. Additionally, it is critical that you enter the correct Prescriber DEA and NPI numbers because Administrator sends correspondence to the Prescriber based on pharmacy Claims. Providing incorrect Prescriber's information can lead to privacy incidents and endanger Member safety.

Identification of the Prescriber requires a National Provider Identifier (NPI). For all Claims, including controlled substance Prescriptions, Network Pharmacy Provider must submit the Prescriber's NPI. If the Prescriber does not have an NPI or Network Pharmacy Provider cannot obtain the Prescriber's NPI after making reasonable efforts to do so, an alternative identifier may be submitted in certain circumstances, as permitted by state and federal guidelines. For example, with respect to commercial Claims, if the Network Pharmacy Provider submits a Submission Clarification

Code (SCC) value to temporarily override a rejection for a non-Type 1 NPI Prescriber ID, it is the Network Pharmacy Provider's responsibility to resubmit the Claim when the Prescriber's Type 1 NPI is found. With respect to Medicare Part D Claims, the Network Pharmacy Provider must submit the Prescriber's valid Type 1 NPI. Section 507 of the Medicare Access and CHIP Authorization Act of 2015 requires Network Pharmacy Provider submitting Claims for Covered Prescription Services include an active and valid Type 1 NPI. Therefore, Medicare Claims with an alternate form of Prescriber identification will not be considered Clean Claims. Additionally, Network Pharmacy Provider must maintain the Prescriber's DEA number on the original hard copy Prescription for all controlled substances in accordance with state and federal laws.

Taxonomy

Individuals prescribing must have prescriptive authority (i.e. the Drug Products being dispensed must be within the Prescriber's scope of practice and they must possess the legal ability to prescribe the Drug Product). To determine prescriptive authority one component of the review should include the Prescriber has a valid taxonomy (i.e. description of the individual's type/class/specialization, such as a nurse practitioner or family medicine physician) appropriately designates prescriptive authority for the Drug Product dispensed. While the Network Pharmacy Provider should maintain records and complete internal validations, Administrator may also review the Claim for potential concerns for prescriptive authority based on taxonomy. Administrator may determine the Prescriber NPI has a taxonomy which does not have prescriptive authority and the Claim will be rejected with the following NCPDP reject code:

Reject Code	NCPDP Description
56	Non-matched prescriber ID

Catamaran Only

If the Network Pharmacy Provider believes the Prescriber is valid and has the appropriate prescriptive authority, the Network Pharmacy Provider may override the rejection by submitting Submission Clarification Code 42 (i.e. Prescriber ID submitted is valid and prescribing requirements have been validated). The Pharmacy should then alert the Prescriber if the taxonomy as documented in NPPES <https://nppes.cms.hhs.gov/> is not accurate and should be updated to prevent future rejections.

Required claim information

For each Claim for a Covered Prescription Service filled and dispensed by a Network Pharmacy Provider for a Member, all related Network Pharmacy Providers are required to transmit the following information to Administrator:

- NCPDP D.0 format billing transaction.
- The payer/billing specification sheet which details all of the requirements for submitting a Claim using the NCPDP D.0 format is referred to as the payer sheet.

Several fields are marked as situational and they will require data as needed under the defined situation in the comment section. Claims submitted that are missing data in mandatory or required fields, or where data is required under situational conditions, will be rejected and will not be a Clean Claim.

With the NCPDP D.0 format change being able to handle the exact metric decimal quantity correctly, you will no longer need to adjust the quantity by rounding prior to submitting Claims. All Claims submitted in D.0 format **MUST** use the PCN of 9999 or 8888 — refer to ID card and a submitted group.



The Administrator have not provided specifications for the American National Standards Institute (ANSI) 837 format, as the Administrator believe that the NCPDP D.0 is the correct format to use for Network Pharmacy Provider dispensed non-Drug Product items. Other non-Prescription products and pharmacy-related supply items should also be billed using the NCPDP D.0 format.

Patient residence code (PRC) and pharmacy service type (PST) requirements

Below is a table of the PRC that Administrator will accept based on the patient residence applicable to each circumstance:

Patient residence	Patient residence code
Not Specified	• PRC of 00
Home	• PRC of 01 — For home and retail
Home Infusion (HI)	• PRC of 01 and place of service (POS System) of 12
Nursing Facility/LTC	• PRC of 03 — Submission clarification code (SCC) required if for short-cycle dispensing
Assisted Living Facility	• PRC of 04
Group Home	• PRC of 06
Intermediate Care Facility/Mentally Retarded	• PRC of 09
Hospice	• PRC of 11

Below is a table of the PST that Administrator will accept based on the pharmacy type applicable to each circumstance:

Pharmacy	Pharmacy service type code
Community/Retail	• PST of 01
Compounding	• PST of 02
HI	• PST of 03
Institutional	• PST of 04
LTC	• PST of 05
Mail Order	• PST of 06
Managed Care Organization	• PST of 07
Specialty Care	• PST of 08
Other	• PST of 99

The pharmacy is required to use the appropriate PRC and PST code for each Claim submitted via the POS System Claim in accordance with NCPDP standards and CMS requirements. Failure to submit the correct PRC or PST code on a Claim (i.e. not in accordance with CMS requirements and NCPDP standards) may result in audit, recoupment of Claim or termination of Agreement.

Please Note:

Claims submitted without an appropriate PRC or PST code may be rejected with:

U7 = Missing/Invalid Pharmacy Service Type 4X = Missing/Invalid Patient Residence
 4y = Patient Residence Value Not Supported 4Z = Place of Service Not Supported By Plan

Prescription origin code claim submission

Network Pharmacy Providers must correctly submit the Prescription Origin Code in conformance with the NCPDP and Administrator requirements.

Please submit one of the following data elements within Prescription Origin Code (419-DJ):

1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile (Fax)

Claims submitted for a Prescription missing one (1) of these values will reject with the following NCPDP Rejection Code 33 — “RX ORIGIN CODE CANNOT BE “0” ON NEW CLM”.

If rejection occurs, please resubmit the Claim with the appropriate value.



To reduce processing errors, please confirm the information on Member’s ID card prior to submitting Claims via the POS System.

Pharmacy processing information and notices

As a reminder, all Claims, including Medicare Part D, must be submitted using the Bank Identification Number (BIN), Processor Control Number (PCN) and Submitted Group (Group) that appears on the Member’s ID card.

Dispense as written (DAW) codes

Administrator supports the NCPDP standard DAW codes. To ensure accurate reimbursement, always include the correct DAW code when you submit a Claim.

Claims submitted to Administrator with DAW codes of three through six (3 thru 6) or eight through nine (8 thru 9) will be adjudicated similarly to a DAW 0. If necessary, contact your software vendor for needed alterations to your pharmacy system.

DAW 0 — NO DISPENSE AS WRITTEN (substitution allowed) (or no product selection indicated)

- Use the DAW 0 code when dispensing a Generic Drug; that is, when no party (i.e., neither Prescriber, nor Pharmacist, nor Member) requests the Brand Name Drug of a multi-source Drug Product.
- Use the DAW 0 code when dispensing a multi-source Generic Drug, even if the Prescriber indicates the DAW code for the Generic Drug and does not specify a manufacturer.
- Use the DAW 0 code when dispensing single-source Brand Name Drugs (e.g., Crestor®), because Generic Drug substitution is not possible.

DAW 1 — PHYSICIAN writes DISPENSE AS WRITTEN

- Use when the Prescriber specifies the Brand Name Drug on the hard copy Prescription or in the orally communicated instructions.

DAW 2 — PATIENT REQUESTED

- Use this code when the Member requests the Brand Name Drug even though the original Prescription did not indicate “DISPENSE AS WRITTEN”.

DAW 3 — PHARMACIST SELECTED BRAND

DAW 4 — GENERIC NOT IN STOCK

DAW 5 — BRAND DISPENSED, PRICED AS GENERIC

- Use when dispensing a Brand Name Drug as a Generic Drug.
- Claims submitted with DAW 5 will be reimbursed at the Generic Drug price.

DAW 6 — OVERRIDE

DAW 7 — SUBSTITUTION NOT ALLOWED; BRAND MANDATED BY LAW

DAW 8 — GENERIC NOT AVAILABLE

DAW 9 — OTHER



Most Members have a choice between a Brand Name Drug and Generic Drugs. However, in some programs the Member will pay the difference between the cost of the Brand Name Drug and the available Generic Drug. Accordingly, correct DAW submissions indicate if a penalty is applicable.

Claims that require a diagnosis

For Claims that requires a diagnosis (dx) submission you will receive a prompt in the POS System requiring you to verify diagnosis information. This requirement is to make sure the diagnosis matches the FDA-approved use or a use supported by the current published evidence. Here’s how to verify diagnosis information:

1. Check for a diagnosis on the Prescription or contact the Prescriber if no diagnosis is listed.
 - a. The Administrator has notified Prescribers of this diagnosis match requirement.
2. Then verify all diagnosis information submitted via the POS System and document verification in your system.
 - a. This information is subject to audit.
3. Enter the ICD-10 code by including the clinical segment (NCPDP segment 13) on the submitted Claim.
 - a. If necessary, please contact your software vendor to make sure the fields indicated are transmitted on the Claims, then populate the fields within this segment as follows:

Field	Field name	OptumRx values supported
111-AM	Segment identification	13= clinical segment
491-VE	Diagnosis code count	Required when diagnosis code is used
492-WE	Diagnosis code qualifier	Required when diagnosis used; 01=ICD10
424-DO	Diagnosis code	Required when diagnosis is needed for designated Drug Product coverage



1. If a diagnosis is missing or excluded from the submitted Claim, you will receive one of the following response messages:
 - NCPDP reject code 39 — Missing Invalid Diagnosis code
 - NCPDP reject code 80 — Submitted Diagnoses Excluded for Product code
2. If a valid diagnosis is not available, please ask the Prescriber and/or Member to request prior authorization per their usual process.

3. The Administrator will approve emergency supplies of these Drug Products according to the following rules when Drug Product therapy needs to begin immediately and prior authorization or diagnosis information is not available.
 - a. Issue up to a 30 day supply or less
 - b. Only fill one Prescription per generic product identifier for diagnosis overrides
 - c. When submitting an emergency supply, please submit the following:
 - i. "Prior Authorization Type code" (Field 461-EU) = '8'
 - ii. "Prior Authorization Number Submitted" (Field 462-EV) = 'DX'
 - iii. "Day Supply" in the Claim segment of the billing transaction (Field 405-D5) = 'N' ; N ≤ 30

Subrogation and coordination of benefits (COB)

Benefit Plans are subject to subrogation and COB rules:

1. Subrogation — To the extent permitted under applicable law and the applicable Benefit Plan, the Administrator reserves the right to recover benefits paid for a Member's Covered Prescription Services when a third (3rd) party causes the Member's injury or illness.
2. COB — is administered according to the Member's Benefit Plan and in accordance with applicable statutes and regulations. Administrator is able to process secondary Claims electronically.



It is prudent for the Network Pharmacy Provider to verify with Members to ensure they do not have alternative primary or secondary insurers. Please be sure to refer to the online transaction response, when applicable, to facilitate COB processing.

Retroactive eligibility changes

Eligibility under a Benefit Plan may change retroactively if:

- Benefit Plan Sponsor or Administrator receives information that an individual is no longer a Member;
- Member's policy/benefit contract has been terminated;
- Member decides not to purchase continuation coverage;
- Eligibility information received by Administrator is later updated; or
- As determined by CMS, with respect to Medicaid, MA-PD or PDP.

If a Network Pharmacy Provider has submitted Claim (s) that are affected by a retroactive eligibility change, a Claim adjustment may be necessary.

Payer sheets

The Administrator D.0 Payer sheets Related to Medicare Part D, Commercial and Medicaid are available on the health care professional's portal via the following:

<https://optumrx.com/RxsolHcpWeb/cmsContent.do?pageUrl=/HCP/HealthcareProviderTools/FormsAndDocuments>



Catamaran payer sheets are available on Catamaran's Pharmacy Resources web-portal: catamaranrx.com/pharmacies (access to the portal will require proper credentials).

B. Formulary

In some programs, Members have a choice between brand and generic Drug Products, however the Member pays the difference between the cost of the brand and the available generic drug. Formularies vary by Benefit Plan and change regularly; the Administrator suggests the use of the Benefit Plan's website or any of the commercially available tools to facilitate formulary management when speaking with Prescribers and Members.

C. Submitting compounded drug claims

Administrator may require Network Pharmacy Providers to complete additional credentialing to be allowed to process Claims for Compounded Drugs. Administrator may solicit a third party vendor, such as United Compounding Management LLC, to assist in the credentialing process. Network Pharmacy Providers will be required to meet all of the credentialing standards established by Administrator and/or the third party vendor to include, but not limited to: PCAB accreditation, continuous quality improvement process inclusive of validation testing for stability and sterility, an ethics management compliance review to include business operations, compliance with Anti-Kickback and Stark law, federal/state pharmacy law, defined allowable sales and marketing conduct, a defined compounding code of conduct and provider manual, and an onsite credentialing review. Network Pharmacy Providers must maintain compliance with credentialing requirements and standards of practice set forth by Administrator or the third party vendor. Failure to maintain compliance with the requirements and standards may result in administrative action up to and including the termination of the Agreement.

Compounded drug claim guidelines:

- Network Pharmacy Provider shall not engage in practices deemed as price rolling. Price rolling is defined as the practice of submitting Claims such that the Network Pharmacy Provider obtains the highest reimbursement possible by circumventing the standard Prior Authorization (PA) process. For example, the Network Pharmacy Provider submits a Compounded Drug Claim and receives a rejection, the Network Pharmacy Provider shall proceed with obtaining a PA. The acts of resubmitting a Claim multiple times with the same quantity and different U&C until a paid Claim is received or upon multiple submissions the quantity is changed to receive a paid Claim, shall be deemed as price rolling.
- During the course of submission of a Compounded Drug Claim, Network Pharmacy Provider may not attempt to obtain higher reimbursement than what was originally submitted as the Network Pharmacy Provider's AWP cost of the ingredients and the U&C. Submission should be for the correct prescribed amount with corresponding accurate quantities and days' supply calculations. In the event a Network Pharmacy Provider receives a paid Claim, it should not attempt to reverse the Claim and obtain higher reimbursements by replacing ingredients (unless Prescriber authorization or new Prescription with different ingredient(s) has been obtained), increasing ingredient costs or dispensing fees or increasing quantities and days' supply calculations.
- Network Pharmacy Provider shall not attempt to circumvent the PA process by either (i) altering the days supply and maintaining the same quantity or (ii) reducing the quantity and the day supply to receive a paid Claim (i.e. such practices are deemed as fee-splitting and is not permitted). For the latter, reducing the quantity of the Prescription and the day supply is permitted if such such change does not cause the Member to incur an increased copayment amount over the life of the Prescription.

- Network Pharmacy Provider shall not submit a Compounded Drug Claim that is an equivalent alternative to a commercially available Drug Product.

Please Note:

Reconstituted preparations (e.g. powdered antibiotics mixed with water prior to dispensing) are not considered Compounded Drug.

- Network Pharmacy Provider shall not submit a Claim for a Compounded Drug for a single NDC pre-made compound or compound kit. These Drug Products should not be submitted with a compound code.

All Claims for Compounded Drugs must be submitted via the POS System using the compounding code indicator of "2" in field NCPDP.0 406-D6 with each ingredient cost submitted by the particular quantity of the NDC and with the applicable Level of Effort (LOE) code in field 474-8E of the NCPDP D.0 format describing the amount of time/work required to produce the Compounded Drug.



Compounded Drug Claims may be subject to quantity limits, dollar thresholds or Prior Authorization (PA) restrictions as defined in the applicable Benefit Plan or Plan Specifications. In addition, Administrator may require Network Pharmacy Providers to complete additional credentialing to be allowed to process Compounded Drug Claims. Administrator may contract with a third-party vendor, such as United Compounding Management LLC, to assist in the Compounded Drug credentialing process. Network Pharmacy Provider will be required to meet all of the credentialing standards established by Administrator and/or the third-party vendor to include, but not limited to the requirements set forth in Section 'Pharmacy network participation requirements' in this PM. When required by the Client or Benefit Plan Sponsor, Network Pharmacy Providers must maintain compliance with compound credentialing requirements and standards of practice set forth by Administrator or the third-party vendor. Failure to maintain compliance with the requirements and standards may result in administrative action up to and including the termination of the Agreement.

The Network Pharmacy Provider is responsible for Compounded Drugs with approved ingredients only. Ingredients need to be within accepted standards strength, quantity and purity. In addition, it must have the appropriate labeling, as well as packaging in accordance with good compounding practices, official standards and scientific information.

All federal legend Drug Products and raw or bulk chemicals submitted in the Compounded Drug Claim fields must be:

- Approved by the Food and Drug Administration (FDA) for safety and effectiveness;
- Purchased from a FDA-registered wholesaler with distribution locations within the United States and point of origin from a FDA-registered manufacturer facility;
- Available only by Prescription;
- Used and sold in the United States; and
- Used for a medically accepted indication to treat a covered condition, illness or injury.

Raw or bulk chemical powders

Many Benefit Plan Sponsors exclude raw or bulk chemicals from their Benefit Plans, including Medicare Part D Benefit Plan. Do not substitute raw or bulk chemical powders in Compounded Drug Claims for manufactured Drug Products when not covered by the Benefit Plan. Always submit the NDC of the Drug Product or raw or bulk chemical component actually dispensed in the Compounded Drug.

Submitting multi-ingredient compounded Prescriptions under version D.0

- Select to all BIN numbers
- Single-ingredient compound billing will not be accepted as a Compounded Drug (submit a compounding code indicator of "1" in NCPDP D.0 field 406-D6)
- Each individual ingredient should be represented by the NDC of the product(s) used and dispensed, including:
 - The total quantity of each specific ingredient
 - The cost of each individual ingredient with basis of cost determination
 - Up to twenty-five (25) ingredients may be entered for each Compounded Drug Claim
- Appropriate fields in the compound segment (see applicable payer sheet for additional information) must be completed.
- Submit the NDC number in the Claim segment as "0" (zero) and the Product/Service Identification qualifier should be submitted as "00" (two zero's).
 - Use the correct NCPDP compound segment to identify each individual ingredient.
- Submit a compound code of 2 (two) in field 406-D6 in accordance with National Council for Prescription Drug Programs (NCPDP) standards as defined in the Administrator payer sheets for Version D.0.
- Submit the quantity dispensed as the total metric quantity of the finished Compounded Drug, including:
 - Sum of all individual ingredient costs as the Network Pharmacy Provider's "Ingredient Cost Submitted" for the Compounded Drug Claim
 - Submit the Network Pharmacy Provider's U&C for the Compounded Drug Claim
- The final cost (calculated total cost/ingredient cost submitted) should be no greater than the combined AWP cost of all ingredients and the Usual and Customary (U&C).
- Compounded Drugs that are Covered Prescription Services shall be reimbursed in accordance with a Network Pharmacy Provider's submitted Claim information subject to any contractual, Benefit Plan or Plan Specifications. The submitted Claim information that may be included in the determination of the Prescription Drug Compensation may include, but are not limited to: the final calculated allowable ingredient cost based on the combined price of the individual Compounded Drug ingredients and quantities in the Compounded Drug, subject to any contractual, Benefit Plan or Plan Specification provisions, in addition to the total ingredient cost or U&C pricing submitted by the Network Pharmacy Provider.

Compliance

Members should be charged the applicable Cost Sharing Amount indicated only. The following actions, including but not limited to, may result in termination from the network:

- Waiving the applicable Member Cost Sharing Amount
- Charging the Member more in Cost Sharing Amount than provided by the POS System, including charging for non-covered ingredients

- Refusing to dispense the Compounded Drug, because of dispute over the reimbursement
- Claim splitting or price rolling by submitting Compounded Drug Claims multiple times by changing the day supply/ quantity/U&C in order to circumvent PAs, or quantity limits, or dollar amount thresholds, or Benefit Plan limits, to obtain multiple dispensing fees or higher reimbursement

Compounded drug claims general exclusions

- Reconstitution of an oral antibiotic or similar product
- Raw bulk chemicals from a non-FDA registered manufacturer facility and wholesaler with locations within the US
- Charges for ancillary supplies, flavoring/sweeteners, equipment depreciation and/or labor are not eligible for reimbursement
- Ingredients with missing or invalid NDC numbers are not eligible for reimbursement
- Mixing of water or saline solution to another Federal Legend Drug
- Compounded Drugs for office use by medical providers and not compounded for individual Members

Re-packaged/Re-imported ingredients

Compounded Drug Claims are subject to audit and to full recovery, including but not limited, for the following reasons:

1. Include as a component of the Compounded Drug a NDC for a repackaged Drug Product, or
2. Drug Product imported or reimported into the United States, including bulk powders utilized in Compounded Drugs where part of the final Compounded Drug dispensed is composed of an imported component

Compensation for compounded drug claims

When covered by the Benefit Plan Sponsor, Compounded Drugs containing raw ingredients packaged as bulk chemicals where an equivalent federal-legend Drug Product is available in the marketplace, the maximum reimbursement for the bulk chemical powders will be the lesser of the Network Pharmacy Provider's Prescription Drug Compensation for each approved ingredient for the NDC utilized or that of the Network Pharmacy Provider's Prescription Drug Contracted Rate for each approved ingredient based on the pricing of the equivalent federal-legend Drug Product. All raw or bulk chemicals must be from FDA-registered chemical manufacturer facilities and wholesalers with distribution locations in the United States.

 Although required at this time, submitting the LOE code may not result in any change in reimbursement on the Compounded Drug Claim.

The following apply to legacy OptumRx BINs:

610084	610094	610097	610127	610279	610494	610613
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Commercial claims (OptumRx BINs Only)

Prescription Drug Compensation for Compounded Drugs dispensed to Members that are Covered Prescription Services will be at the pharmacy's contracted Prescription Drug Contracted Rate for each approved ingredient submitted for the applicable network associated with the Claim submission, plus a Compounded Drug dispensing fee not less than \$7.50. This fee is subject to change by Administrator and may differ by Benefit Plan.

Medicaid claims (OptumRx BINs Only)

Unless otherwise specified below, Prescription Drug Compensation for Compounded Drugs dispensed to Medicaid Members that are Medicaid Covered Prescription Services will be at the Network Pharmacy Provider's agreed upon Prescription Drug Contracted Rate for each approved ingredient submitted for the applicable network associated with the Claim submission, plus a Compounded Drug dispensing fee not less than \$20.23. This dispensing fee is subject to change by Administrator and may differ by Benefit Plan.

Medicare Part D claims (OptumRx BINs Only)

The Prescription Drug Compensation for Compounded Drugs dispensed to Medicare Part D Members that are Medicare Part D Covered Prescription Services will be at the Network Pharmacy Provider's agreed upon Prescription Drug Contracted Rate for each approved ingredient submitted for the applicable network associated with the Claim submission, plus a Compounded Drug dispensing fee not less than \$19.72. This fee is subject to change by Administrator.

Processing a compounded drug claims with non-covered ingredients

In the event a non-covered ingredient is submitted in the Compounded Drug Claim, the Claim will reject and the POS System response will inform the Network Pharmacy Provider which ingredients were rejected and the Compounded Drug Claim may be resubmitted with a Submission Clarification code of "08" (i.e. zero-eight). The resubmitted Compounded Drug Claim will adjudicate and reimbursement will exclude the non-covered ingredients. Network Pharmacy Providers may not charge the Member more than the Cost Sharing Amount provided by the POS System, including for non-covered ingredients.

D. Pharmacy payment

Administrator, acting on behalf of applicable Client or Benefit Plan Sponsor will process the Clean Claim for each Covered Prescription Service dispensed to applicable Members. Administrator will reimburse pharmacy for each Clean Claim no later than thirty (30) calendar days after Administrator's receipt of the Clean Claim, or a lesser time if required by applicable law or regulation, and contingent upon Client or Benefit Plan Sponsor funding.

Processing and pricing; successful adjudication of a claim

The acceptance of a successfully adjudicated Claim constitutes (i) Network Pharmacy Provider's acknowledgment of its participation in the applicable network and (ii) Network Pharmacy Provider's acceptance of all corresponding terms and conditions, including the rates and reimbursements of Claims, for such network. In the event of a conflict between the PM, Agreement, addendum, Compensation Exhibit, fee schedule, POS System transaction response reimbursement or any other pricing arrangement, the POS System transaction response reimbursement shall govern, unless an error in overpayment occurs.

Claims submitted by Network Pharmacy Provider for Members using an Administrator network or Client network via the POS System for retail prescription benefit management or Claim processing are reimbursed at the lesser of the following: the Benefit Plan or network AWP discount or other referenced based pricing plus applicable dispensing fee; MAC (when applicable for Covered Prescription Services); Network Pharmacy Provider's Submitted Cost Amount; Network Pharmacy Provider's U&C which would be given under the same circumstances if the Member did not possess prescription benefit coverage; or the submitted ingredient cost. Network Pharmacy Provider payments must be reconciled by Network Pharmacy Provider (e.g. if Network Pharmacy Provider receives a payment from

Administrator with incorrect NPI, NCPDP number, name, address, Prescriptions processed by Network Pharmacy Provider or other key identifiers, Network Pharmacy Provider must report the discrepancy via telephone and in writing, such as electronic or otherwise), to Administrator within fourteen (14) days upon receipt.

Determination of payment accuracy will occur by Administrator within fourteen (14) days. In the event any payment has been sent to a Network Pharmacy Provider in error, Network Pharmacy Provider is subject to immediate offsets from future payments or is required to immediately reimburse Administrator via a bank-drawn check or electronic fund transfer as directed by Administrator. Knowledge or lack thereof, of overpayment provides no rights to the receiver (i.e. Network Pharmacy Provider), all payments must be returned immediately as described above and interest at the greater rate of 1.5% per month of the total balance or required by law. Knowledge by Network Pharmacy Provider of extended (greater than 30 days) overpayment may be subject to network termination, penalties, including, but not limited to court costs, collection agents, travel and attorney's fees as required to recover the funds.

Payments

Administrator typically administers up to six (6) payment cycles per month. Administrator reserves the right to make payment directly to a Network Pharmacy Provider at its sole discretion.

Network Pharmacy Provider shall not pursue payment for services or other additional fees from any other source. Network Pharmacy Provider agrees it is prohibited from contacting Administrator Clients and Members for disputed issues between Network Pharmacy Provider and Client or Administrator. Network Pharmacy Provider agrees it is prohibited from directing the Member or a Member's Claims to a plan or Client other than the Administrator plan presented by the Member. Violation of such prohibitions is considered a breach of Agreement and subsequently subject to penalties or sanctions as determined by Administrator.

Network Pharmacy Provider is subject to penalties or sanctions in the event it is determined by Administrator during communications between Network Pharmacy Provider and an existing Client or a potential Client: (i) Network Pharmacy Provider disclosed confidential information to a Client or a potential Client or (ii) disrupted an Administrator relationship with its existing Client or with a potential client. Penalties shall be invoked in amounts at a minimum of \$5,000 per incident/per day; may be subject to additional actions taken by Administrator, including and up to termination from participation, as well as withdrawal and/or the holding of funds as deemed necessary by Administrator.

If Network Pharmacy Provider is affiliated with a third party contracting or purchasing group, the Network Pharmacy Provider is subject to all terms/conditions of the written Agreement between Administrator and the entity. Communication should also be directed through the third party contracting entity or purchasing group.

Payment rules under Medicare and Medicaid programs

In accordance with requirements as set forth in 42 C.F.R §423.520(a)-§423.520(h) Network Pharmacy Provider Claims will be paid as follows:

Clean claims

- For Medicare Part D Plan Sponsor Clean Claims will be paid within fourteen (14) days of the date of receipt for electronic Claims and within thirty (30) days of receipt for paper Claims.
- For managed Medicaid, Clean Claims will be paid within thirty (30) days of the date of receipt for electronic Claims and within thirty (30) days of receipt for paper Claims, except where a state requires a shorter timeframe, in which case, state requirements prevail.

Claims

- If the Claim is determined not to be a Clean Claim, Administrator will notify the submitting Network Pharmacy Provider. This notification will specify all defects or improprieties in the Claim and will list all additional information necessary for the proper processing, as well as payment of the Claim, if applicable.
- Administrator will not provide notice of a new deficiency that could have been identified in the original Claim submission.
- Medicare Supplier Number. Administrator encourages Network Pharmacy Provider to obtain and maintain for each Network Pharmacy Provider location a Medicare Part B supplier number pursuant to 42 CFR § 424.57. Network Pharmacy Provider agrees to inform Administrator of the Medicare Part B supplier number assigned to those Network Pharmacy Providers which have obtained such supplier numbers from CMS for record-keeping purposes and to identify those Network Pharmacy Providers as having Medicare Part B supplier numbers in the pharmacy network directories maintained by or on behalf of Clients.

Effective January 1, 2016 and to the extent required by 42 C.F.R. § 423.505(i)(3)(vii), Administrator will disclose all individual updated Drug Product prices to the applicable Network Pharmacy Provider in advance of the use of such prices for reimbursement of applicable Claims if the source for any Prescription Drug Product pricing standard is not publicly available.

Payment of interest

A Claim submitted to Administrator for payment not paid within the established timeframe (i.e. fourteen (14) days for electronic Claims or thirty (30) days for paper Claims) will receive interest payments where required by law, except: (i) where a state requires a shorter timeframe, in which case, state requirements prevail or (ii) is contested by Administrator and determined to be a Clean Claim.

The rate of interest is calculated as the rate equal to the weighted average of interest on three (3) month marketable treasury securities determined for such period, increased by 0.1 percentage point for the period beginning on the day after the required payment date and ending on the date on which the payment is made.

Any interest amount associated with a Claim is included within the Claim cost as deemed appropriate for reporting purposes by CMS or our Clients. As CMS determines, interest is not charged under exigent circumstances preventing the timely processing of Claims, including natural disasters, as well as other unique and unexpected events.

Electronic remittance advice (ERA) 835 program enrollment requirements

Administrator Network Pharmacy Providers have the option to participate in the ERA 835 program. This service provides improved analysis, reporting, and a cost-effective alternative to the traditional “hard copy” or paper copy remittance advice.

To use the Administrator ERA program, you must meet the following requirements:

- Be a current Administrator Network Pharmacy Provider.
- Have the ability to receive and read the ERA 835 file. Check with your Information Technology support staff or pharmacy software provider to confirm that you have the ability to receive the encrypted Claims information via File Transfer Protocol (FTP).
 - CMS also offers free software to view and print the ERA 835 file for professional providers and suppliers. For

more information on this software, Medicare Remit Easy Print (MREP).

— Please access the CMS website at: <http://cms.hhs.gov/>

— When converting from a paper remittance advice to an ERA, the paper remittance advice can be mailed to you upon your request. This can be done for up to thirty one (31) days once you are enrolled in the EFT payment process.

- Complete the Pharmacy ERA paper enrollment form containing your contact and banking information. Please allow four weeks for your enrollment to be processed. Claims received after your Pharmacy EFT enrollment has been processed will be paid electronically.
- Complete the server information section on the enrollment form. To complete the server information you will need to provide your “PGP Key”. This ensures the delivery of secure data. PGP (Pretty Good Privacy) Encryption is a computer program that provides cryptographic privacy and authentication. PGP and similar products follow the Open PGP standard for encrypting and decrypting data. You will need to get this information from your software vendor.

ERA enrollment steps

OptumRx

To enroll in Administrator ERA Program for OptumRx payments, please go to **optumrx.com** and access the Healthcare Professionals — Pharmacy Electronic Remittance Advice (ERA) section.

Once you are enrolled in the ERA program, you can call the Network Contracting Department at **1-800-613-3591** if you have questions about a late or missing ERA.

Catamaran

To enroll in Administrator ERA Program for Catamaran payments, please go to **catamaranrx.com/pharmacies** (access to the portal will require proper credentials).

Electronic funds transfer (EFT) program enrollment requirements

Administrator Network Pharmacy Providers have the option to participate in the electronic funds transfer (EFT) program. This service provides improved analysis, reporting, and a cost-effective alternative to the traditional “hard copy” process.

OptumRx

To use the Administrator EFT Program for OptumRx payments, you must meet the following requirements:

- Be a current Administrator Network Pharmacy Provider.
- Be a current recipient of the ERA 835.
- Complete the Pharmacy EFT enrollment form containing contract and banking information.
- Please allow four (4) weeks for your enrollment to be processed.
- Claims received after your EFT enrollment has been processed will be paid electronically.

EFT enrollment steps

To enroll in Administrator EFT program for OptumRx payments, please go to **optumrx.com** and access the Healthcare Professionals — Pharmacy Electronic Funds Transfer (EFT) section.

Once you are enrolled in the EFT program, you can call the Network Contracting Department at **1-800-613-3591**

if you have questions about a late or missing EFT.



- Once you are enrolled in the Administrator EFT program, a paper remittance can be mailed for 31 days after your conversion, but you must request it.
- ERA 835s will be delivered to Network Pharmacy Provider or payee via Administrator external Client “Gateway”.
 - File can either be sent via Secure FTP or they can be retrieved from the Gateway.
 - Files cannot be delivered in any other method (e.g., compact disk (CD), email, etc.).
- The EFT section at **optumrx.com** also contains instructions to cancel or make changes once enrolled in the Administrator EFT Program.

Catamaran

To enroll in Administrator EFT Program for Catamaran payments, please go to **catamaranrx.com/pharmacies** (access to the portal will require proper credentials).

E. Member/Insured appeals and grievances

Administrator has established mechanisms to ensure all Members and Prescribers have equal access to, and can fully participate in, the appeals process. Either the Member or the Member’s appointed representative and/or Prescriber can initiate an appeal. Members should refer to the denial letter for information regarding their appeal and grievances.

Member complaints or grievances are a means of continually improving the quality of our services. Grievances requested as directed above will be handled in a timely manner.

F. Utilization management

Utilization management requirements for select drugs

Some Covered Prescription Services may have additional requirements or limits that help ensure safe and effective use. Requirements and limits may include:

Prior authorization (PA) Select Drug Products may have potential for inappropriate or unsafe use. Therefore, Benefit Plan Sponsor approval is required to ensure that the Drug Product will be used for indications for which it has been shown to be safe and effective. Drug Products subject to PA may require confirmation of diagnosis or submission of laboratory and other supporting information.

Step therapy (ST) Step therapy promotes the use of one or more alternatives which are safe and cost-effective prior to receiving approval for the requested Drug Product. The recommended alternatives are considered preferred or first-line Drug Products that are consistent with standard medical care and evidence-based literature. Once Members have tried the alternatives without success, the requested Drug Product requiring ST may be approved for coverage.

Quantity limits (QL) QL ensure safe Drug Product use by preventing excessive dosage amounts or extended periods of therapy without clinical justification. They limit the amount of Drug Product a Member can receive by identifying a maximum quantity that can be dispensed over a specific period of time or per Prescription. They may also be used to promote dose optimization which encourages Members to use the most appropriate strength based on their dosing regimen. Certain Drug Products may be approved for quantities above the limited amount, if medical necessity can be substantiated.

This PA review process applies to the applicable additional requirements or limits: PA, ST and QL

PA review. A Member, Member's appointed representative and/or a Prescriber may submit a request to initiate the PA review process. Coverage determinations made through the PA review process will be based on Benefit Plan's approved criteria, clinical guidelines approved by the National Pharmacy & Therapeutics Committee (NP &TC) or other professionally recognized standards of practice. If a Member's Drug Product has a PA, ST or QL restriction, the Member or his/her appointed representative should contact Administrator customer service number located on the back of the Member's ID card. In addition, the Prescriber may contact our PA Department to start the prior authorization process by providing relevant, patient-specific clinical information to be reviewed by a licensed Pharmacist or medical director.

Prescribers can also submit a PA request via fax, mail, or online at:

<https://optumrx.com/RxsolHcpWeb/cmsContent.do?pageUrl=/HCP/PAForms/ProviderPAForms>

Prior authorization (PA) process key steps

- The Member's Prescriber or Member's appointed representative can submit a PA request.
- A pharmacy technician enters the information into our PA system and performs the initial request review.
- If the request falls outside the established guidelines, a Pharmacist reviews the request and contacts the Prescriber if additional information is required.
- If required by state law, the request will be reviewed by a medical director before issuing the final decision.
- Additionally, where required by law, the Prescriber is offered the opportunity for a peer-to-peer consultation prior to the issuance of an adverse medical necessity determination.

Once the request is approved or denied, our PA system will automatically generate a written correspondence to both the Member and Prescriber.

The Administrator complies with all State and Federal regulations for PA turnaround time. Our typical turnaround times are as follows:

- Non-urgent cases have a turnaround time of fifteen (15) days for commercial Benefit Plans, or seventy-two (72) hours for Medicare Benefit Plans from receipt of all information required to review the case.
- Urgent cases have a turnaround time of seventy-two (72) hours for commercial Benefit Plans, all information needed to review the case or seventy-two (72) hours for Medicare Benefit Plans from receipt of Prescriber supporting documentation.

Additional information

Our PA department is staffed with licensed pharmacists and pharmacy technicians. They also have access to a physician reviewer when required. After PA requests are reviewed, determinations are rendered in accordance with State and Federal regulations, independent body accreditation standards, such as National Committee for Quality Assurance (NCQA), or Employee Retirement Income Security Act (ERISA), and the clinical guidelines developed by our National Pharmacy and Therapeutic (NP&T) guideline subcommittee. The Prescriber and Member or authorized representative will be notified of the final decision within the required time frame according to State and Federal regulations.

Maximum dollar edits (Max)

Some Benefit Plans may elect to implement a high cost dollar limit (i.e. amounts vary by Benefit Plan). The ceiling amount for high cost dollar limits may vary by Benefit Plan. If the Claim rejects (reject code 78) for this reason, please contact the Pharmacy Help Desk to determine if the Member's Benefit Plan will allow for an override.



Do not 'split' the Prescription into multiple Claims.

G. Concurrent drug utilization review (cDUR)

In order to detect and address clinical quality and safety issues, certain Concurrent Drug Utilization Reviews (cDURs), or clinical edits, are applied at the time the Prescription is dispensed. Concurrent screenings are for such things as duplicate therapies, age or gender-related contraindications, overutilization or underutilization, drug-drug interactions, incorrect drug dosage or duration of drug therapy, drug-allergy contraindications, and clinical Abuse or misuse. System thresholds/criteria and accompanying pharmacy messaging are developed and set by Medi-Span® and are validated and implemented by Administrator. Certain clinical edits are set up as messages or rejects depending on the Clients' cDUR program setup. Dispensing Pharmacists should exercise their clinical knowledge and expertise in reviewing and overriding warning messages if deemed medically appropriate.

Override codes for pharmacy

Certain Benefit Plans allows overrides for clinical edits. Administrator also utilizes NCPDP defined DUR/Pharmacy Payment Service (PPS) Coding (Conflict, Intervention and Outcomes Codes) and Submission Clarification Codes.

The following reject edits allow Network Pharmacy Providers to be able to review and override certain DUR rejections/interactions by identifying and entering the appropriate conflict, intervention and outcome codes for each component.



The use of each submission clarification code for the purpose of overriding the rejection is based on Benefit Plan. Therefore if the benefit does not allow Vacation override, for example, submission clarification code 03 (corresponding to vacation supply) will not override the rejection. Likewise, if the Benefit Plan does not cover lost Prescription, submission clarification code 04 (corresponding to lost Prescription) will not override the rejection. Some Benefit Plans require calling Pharmacy Help Desk for overrides (e.g. Medicare Part D Benefit Plans).

Reason code TD (Therapeutic Duplication), you will be required to review the flagged medications and resolve any duplication in the system.

This TD is a safety edit in the pharmacy system that looks at the member's current medications and compares them to the drug you are processing. It flags a patient's request to fill a medication within that same class of medication already filled within the last 30 days. The flag requires you to research why the patient is attempting to fill another medication in the same class so quickly.

When the pharmacy system flags a medication for TD, it produces a soft reject. The following steps explain how you review and override a soft reject:

1. Review the patient profile to identify why the system identified the member with a therapeutic duplication. There may be claims from other pharmacies that resulted in the soft reject.
2. Consult with the member to confirm current medications.
3. If the member is unsure or insists they should be taking both medications, or if you have additional questions, please ask the prescriber to confirm.
4. If you do not recommend the prescription, do not fill it. Ask the member to contact the prescriber. Do not submit a claim for the prescription.
5. If you approve the prescription fill, override the rejection. Identify and enter the appropriate Reason, Professional, and Result Codes for each component that applies to the situation. You may enter only one code for each field.

Select the appropriate Professional and Result Codes from the following list.

Professional Codes	Professional Code Description	Result Codes	Result Code Description
M0	Prescriber consulted	1A	Filled as is, False Positive
P0	Patient consulted	1G	Filled, Prescriber approval
PE	Patient education/instruction	3A	Recommendation Accepted
TH	Therapeutic product interchange	3C	Discontinued drug
		3D	Regimen changed
		3E	Therapy changed

Edit name; reject code	Description of edits	Action; DUR/PPS coding and submission clarification codes
Drug-Drug Interaction (DDI); Drug Therapy Monitoring System (DTMS) Screening; Reject 88	Checks Member's Prescription history to detect possible adverse interactions between submitted drug and others being taken by the Member.	<p>Pharmacists review the patient profile to identify why the reject has occurred, consult with the prescriber, determine if the drug should be dispensed and if appropriate, override the rejection with the following DUR/PPS coding:</p> <p>Drug Conflict Code —</p> <ul style="list-style-type: none"> Reason for service code ("conflict code") = DD for drug-drug Interaction <p>DUR Intervention Code —</p> <ul style="list-style-type: none"> Professional service code ("intervention code") = M0 for prescriber consulted = R0 for pharmacist consulted (commercial only) or = P0 for patient consulted (commercial only) <p>DUR Outcome Code —</p> <ul style="list-style-type: none"> Result of service code ("outcome code") = 1G for filled, with prescriber approval = 1B for filled Prescription as is
Dosing Screening (DOSECHEK); Reject 88	Compares dosage of submitted drug with the maximum recommended dosage for Member's age to detect possible conflict.	<p>Pharmacists review the patient profile to identify why the reject has occurred, consult with the prescriber, determine if the drug should be dispensed and if appropriate, override the rejection with the following DUR/PPS coding:</p> <p>Drug Conflict Code —</p> <ul style="list-style-type: none"> Reason for service code ("conflict code") = HD for high dose alert <p>DUR Intervention Code —</p> <ul style="list-style-type: none"> Professional service code ("intervention code") = M0 for prescriber consulted = R0 for pharmacist consulted (commercial only) or = P0 for patient consulted (commercial only) <p>DUR Outcome Code —</p> <ul style="list-style-type: none"> Result of service code ("outcome code") = 1G for filled, with prescriber approval = 1B for filled Prescription as is

<p>Too Soon: Reject 79</p>	<p>Checks Member's Prescription history to detect possible duplicate Prescriptions.</p>	<p>Pharmacists review the patient profile to identify why the reject has occurred, consult with the prescriber, determine if the drug should be dispensed and if appropriate, override the rejection with the following submission clarification codes (420-DK)**:</p> <ul style="list-style-type: none"> • 03 Vacation supply — The pharmacist is indicating that the cardholder has requested a vacation supply of medicine. • 04 Lost Prescription — The pharmacist is indicating that the cardholder has requested a replacement of medication that has been lost • 05 Therapy change — The pharmacist is indicating that the physician has determined that a change in therapy was required: either that the medication was used faster than expected, or a different dosage form is needed, etc.
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H. Retrospective drug utilization review (rDUR)/clinical program

The Retrospective Drug Utilization Review (rDUR)/Clinical Program use detailed data review and analysis to identify potential problems, implement appropriate interventions, and evaluate the impact of the interventions. Clinical programs can yield measurable results, including reduction in emergency room visits, unnecessary and inappropriate Drug Product use, and overall costs. The programs focus on pre-catastrophic populations with high-cost and high-impact conditions that have the greatest potential for improvement via Member and/or Prescriber interventions. Specific program objectives include optimizing the use of certain therapeutic agents to improve health outcomes, reducing the risk for Drug Product-related adverse events, and promoting the use of the most cost-effective Drug Products.

 Clinical program examples include, but are not limited to, the following:

Drug-drug interaction alert program (DDIAP)

Some Drug Products can have harmful effects when used in conjunction with others. These potentially dangerous drug-drug interactions (DDIs) can negatively impact Members' health and increase both Prescription and medical plan costs. DDIAP helps to protect Members from potential Drug Product-related adverse events by notifying Prescribers when a clinically significant DDI has been identified. Claims are reviewed daily to detect clinically significant DDIs which are categorized as a combination of Drug Products that should always be avoided or a combination that should usually be avoided. When Members who filled Drug Products with potentially serious DDIs are identified, their Prescribers receive a faxed letter and report within twenty-four (24) to seventy-two (72) hours.

Each report provides details on the clinically significant DDIs found for Members under the specific Prescriber's care.

Drug-age RxMonitor program

Certain Drug Products are not recommended in the elderly, age sixty-five (65) years and older, as well as pediatric ages less than nineteen (19) years, because of potential side effects or lack of effectiveness. The Drug-age RxMonitor program can reduce the use of these potentially inappropriate Drug Products among elderly and pediatric Members while improving quality of care. Using Claims data, the Administrator identifies Members that meet the program's age thresholds and have filled one or more high-risk Drug Products that should be avoided in that age group. High-

risk Drug Products in the elderly are determined based on applicable Health Plan Employer Data and Information Set (HEDIS® criteria). Prescribers receive a fax or Mailing containing an introductory letter, a Prescriber-specific report of identified Members and Drug Products of concern

Narcotic drug utilization review (DUR) program

While opioid analgesics, benzodiazepines, muscle relaxants, and acetaminophen (APAP)-containing Drug Products are an important part in managing pain and other medical conditions for many patients, these Drug Products are often associated with Abuse, diversion and inappropriate use. The Narcotic DUR program identifies Members that may benefit from having their Drug Product regimens re-evaluated by their Prescriber. This program improves the quality of patient care by reducing potentially inappropriate usage of opioids, benzodiazepines, muscle relaxants, and APAP-containing Drug Products. The Administrator retrospectively review and analyze Claims data to identify Members who meet at least one (1) criteria: overlapping use of different long-acting opioid Drug Products; multiple Prescribers prescribing opioids, benzodiazepines, or muscle relaxants; multiple Network Pharmacy Providers dispensing opioids, benzodiazepines, or muscle relaxants; high doses of opioids; chronic early refills of oxycodone-containing products; excessive days' supply of opioids; and total average daily APAP dose exceeding four (4) grams. Prescribers receive a fax or Mailing containing an introductory letter and a Prescriber-specific report of identified Members.

Opioid overutilization drug utilization review (DUR) program

CMS requires all Medicare Part D Sponsors to implement a drug utilization management program to help prevent overutilization of prescribed opioid Drug Products. The Opioid Overutilization DUR program addresses potential overutilization of opioids in Prescription drug Benefit Plans through improved drug utilization controls and Member-level case management. The goal of this program is to identify and case-manage Members with excessive use of opioid Drug Products considered to be potentially unsafe, and to reduce FWA. Members identified as receiving a relatively high dose of opioid Drug Products for a long period of time and receiving these opioid Drug Products from multiple Prescribers and Network Pharmacy Providers will have a case manager assigned to conduct Prescriber outreach to confirm if the current dosage of opioids is medically necessary and safe for each Member. Based on the results of this retrospective review, a Member-level POS System edit may be implemented limiting the use of opioids for Member safety. Not all Members will have a POS System edit implemented. Members receiving an opioid restriction will be notified at least thirty (30) days in advance of the effective date of the restriction to provide time for a coverage determination to be processed.

Polypharmacy program

The use of an excessive number of Drug Products to treat one or more medical conditions, also known as polypharmacy, can lead to serious health complications for Members, as well as increased pharmacy and medical costs. To lower the health risks associated with polypharmacy, the Administrator offers two actionable, Prescriber-based interventions designed to reduce polypharmacy issues. Our Polypharmacy Duplicate Therapy Program uses Claims data to identify Members taking two (2) or more duplicate Drug Products (i.e., Drug Products with duplicate therapeutic effects and intended to treat the same condition) while our Polypharmacy Drug-Disease Interaction Program uses pharmacy and/or medical Claims data to identify Members taking Drug Products that may adversely interact with their existing conditions. Prescribers receive a fax or Mailing containing an introductory letter, a Prescriber-specific report of identified Members and information they can use to assess their patients' polypharmacy issues.

Refill reminder and adherence program

Adherence is defined as taking a Drug Product as prescribed by a healthcare professional. As compared to non-adherent Members, adherent Members have a lower likelihood of hospitalization, emergency room visits and condition-specific healthcare costs. To promote adherence, the Refill Reminder and Adherence Program provides refill reminder interventions for non-adherent Members and engages their providers with the goal of increasing adherence to chronic Drug Products and decreasing healthcare costs. These programs use pharmacy and medical Claims data to identify Members which are non-adherent to any Drug Product within certain Drug Product classes. Examples of targeted Drug Product classes include, but are not limited to, the following: antidepressants, antiretroviral HIV/AIDS Drug Products, diabetes Drug Products, and statins. Members are reminded to refill their Drug Products via fax, mailing, HIPAA-compliant, and/or outbound calls from an automated message delivery system. Prescribers receive a mailing containing an introductory letter and a Prescriber-specific report detailing Members who may be non-adherent to Drug Product(s) within the targeted Drug Product class(es).

Generic strategy program (GSP)

The GSP is designed to promote the use of clinically appropriate lower-cost Generic Drugs. The program targets newly available and existing Generic Drugs in select therapeutic classes.

Examples of targeted Drug Product classes include, but are not limited to, the following: angiotensin receptor blockers (ARBs), bisphosphonates, nasal steroids, and proton pump inhibitors. Members and their Prescribers, identified through Claims data, receive letters regarding the availability of Generic Drugs, the safety and efficacy of Generic Drugs and cost savings associated with the use of Generic Drugs. In addition, Prescribers also receive a report of their identified patients who could benefit from switching from a Brand Name Drug to Generic Drug.

I. Maximum allowable cost (MAC) pricing, review and appeals

To assure the MAC list accurately reflects market pricing and the availability of Generic Drugs, Administrator utilizes multiple sources to determine MAC pricing. The sources include de-identified market pricing benchmark data such as AWP and WAC, wholesaler information on market availability and pharmacy information from inquiries. A synthesis of these and other sources helps create a market based MAC price for Generic Drugs on the MAC list. These sources are also monitored and updated at least every seven (7) calendar days to timely help manage market pricing fluctuations on the MAC list. Administrator's MAC lists are also regularly reviewed and updated accordingly. Administrator reserves the right to update its MAC pricing methodology and to use alternative, reputable sources at its discretion. Upon written request, as well as to the extent required by law, Administrator will make available the current and applicable MAC price information to Network Pharmacy Provider. Such MAC price lists constitute confidential information.

To comply with applicable state laws, Administrator has implemented an appeals process to allow a participating network pharmacy to dispute applicable and particular MAC pricing of a Covered Prescription Service Drug Product (i.e. MAC Appeal). This process also includes a timely review and investigation to resolve MAC disputes. For a MAC Appeal, pharmacy must obtain, fully complete and submit the MAC a Appeal form ("MAC Form") to Administrator within thirty (30) calendar days from the date of service submitted on the Claim, as well as adhering to state-specific requirements. For pharmacies contracted with a PSAO, all appeals must be submitted through your PSAO for submission to Administrator. Administrator shall investigate and resolve the appeal within thirty (30) business days after the fully completed form is received. This section shall be considered a part of the Agreement by and between Administrator and Network Pharmacy Provider (including all amendments, addenda or Compensation Exhibits) to the

extent the Network Pharmacy Provider provides Covered Prescription Services to Members in applicable states. The terms of this section shall be considered general information regarding MAC. Network Pharmacy Provider agrees and understands to the extent any state-specific law, rule or regulation differs or contradicts the terms set forth herein, Administrator shall follow the state-specific law, rule or regulation. Network Pharmacy Provider is subject to any MAC list(s) associated with the network(s) in which Network Pharmacy Provider participates

Review requests will be reviewed to determine the appropriateness of pricing utilized by Administrator for reimbursement. Administrator will utilize all available information to deduce the appropriateness of reimbursement. Participating pharmacies must submit their actual acquisition cost (including any rebates) for each item being reviewed. Failure to submit the actual acquisition cost (including rebates) will not result in Administrator rejecting Claims for review, but could diminish the accuracy of review and therefore the likelihood of a successful and complete review.

MAC state-specific

To the extent your pharmacy is located in a state that requires different time periods to submit or resolve MAC Appeals than noted above (see Appendix).



Administrator follows the state requirement where your pharmacy is located. In addition, if your pharmacy is located in one of the following states, the respective below provision supplements or replaces that aspect of the MAC Appeal process. Not all state requirements apply to all Claims or all lines of business (e.g. Commercial, Medicare, Medicaid and ERISA exempt Benefit Plans).

J. Resubmitting a claim

All Claims submitted via the POS System will result in a response Transaction message (e.g. Paid or Rejected). In the event that Network Pharmacy Provider has submitted a Claim via the POS System and Network Pharmacy Provider does not receive any Claim response Transaction message via the POS System within a reasonable amount of time, Network Pharmacy Provider should verify the accuracy of the submitted Claim and resubmit the Claim to Administrator via the POS System.

K. Transmission fees

Variation transmission fees will be incurred by the Network Pharmacy Provider per online Transaction. Fees are assessed to support Network Pharmacy Provider payment, as well as reconciliation, Help Desk service, education regarding network compliance, transactional and billing processes, among other initiatives. However, excessive or disruptive process inquiries, including, but not limited to non-contracted pharmacy status, duplicate payment and remittance requests, excessive Member/Network Pharmacy Provider grievances, third-party biller intervention, incomplete or inaccurate credentialing submissions, contract noncompliance and/or failure of the Network Pharmacy Provider to submit Claims through the Administrator designated claim processor POS System, are subject to higher transmission fees. Should a Claim be submitted by a third-party or other means separate from the Network Pharmacy Provider itself, the Claim may be subject to non-payment.

L. Pharmaceutical manufacturers copayment coupons

Network Pharmacy Provider is responsible for ensuring pharmaceutical manufacturer copayment coupons are not utilized for Medicare Part D Claims and other payments for federal health programs. Network Pharmacy Providers must include operational practices that require the validation of each customer that presents a copayment card which is not covered by a government health plan.

Copayment coupons may be presented in several different forms, including printed/electronic coupons, debit cards or direct payments from the manufacturer to the Member. Copayment coupons will typically bear a statement indicating beneficiaries of federal health care programs may not use the coupon.

Network Pharmacy Providers accepting manufacturer coupons for copayments owed by federal health program beneficiaries may be subject to sanctions under the anti-kickback statute, the beneficiary anti-inducement provision of the Civil Monetary Penalties Law (CMPL) and the False Claims Act. In addition, non-compliance with this provision may result in remedies, including, but not limited to a corrective action, probation, termination of the Agreement and any other available recourse.

M. Tax

Tax is calculated based on the applicable state or local law governing tax on Prescription Drug Products. In order to be reimbursed for payment of tax, Network Pharmacy Provider must enter the tax amount in the appropriate field on the Claim submission.

N. Disputed claims

In the event a Network Pharmacy Provider seeks to dispute a Claim due to alleged error, miscalculation, discrepancy or noncompliance to terms specified in the Agreement or otherwise questions the accuracy of any Claim, the Network Pharmacy Provider must notify Administrator within one-hundred and twenty (120) days of the date of fill in writing. Written outreach must include Pharmacy NCPCP number, Eligible Person ID number, Prescription number, date of fill and details such as why an adjustment is needed (e.g. wrong NDC submitted, wrong quantity submitted, etc.) Should the Network Pharmacy Provider fail to contact Administrator within the required response time, Network Pharmacy Provider deems the accuracy of processing and payment of Claims, as set forth in that cycle. Overpayments made to the Network Pharmacy Provider are not applicable.



Notifications may be emailed to: **pharmacycontracts@optum.com** (OptumRx) or **provider.relations@optum.com** (Catamaran)

O. Days supply and quantity

Network Pharmacy Provider may only submit Claims to Administrator for Drug Products properly labeled and dispensed in accordance with the Prescription order for the Drug Product.

Days' supply

Network Pharmacy Provider is responsible for entering the correct days' supply of Prescriptions for all Claim submissions. The supply should accurately reflect the documented directions and quantity dispensed. Audits routinely identify discrepancies in days' supply errors. Treatment therapy should be included in determination of days' supply. The following are examples of appropriate days' supply submission:

- a. One (1) patch weekly is four (4) patches for a twenty-eight (28) day supply.
- b. Two (2) tablets twice weekly is eight (8) tablets for a twenty-eight (28) day supply.
- c. A thirty (30) day supply is no longer standard; some programs permit extended days' supplies. Always transmit the accurate days' supply and allow the on-line system to communicate the allowable days' supply.

Dispensing limitations

Any Claim submitted to Administrator exceeding Benefit Plan limitation for the days supply or quantity dispensed will reject with messaging indicative of actual plan limits such as: MAXIMUM DAYS SUPPLY- thirty-four (34) or QUANTITY LIMIT -100. Resubmitted Claims must include the accurate days supply and quantity. If a Claim submitted has a quantity representative of the smallest commercially available package size or represents a single course of therapy (e.g. Seasonique® as a ninety-one (91) day supply) and rejects as stated, the Network Pharmacy Provider must request an override through the Pharmacy Help Desk and resubmit the Claim utilizing the quantity and the accurate days supply.

Network Pharmacy Provider must clarify ambiguous dosage instructions regarding use prior to dispensing a Prescription. If a prescription contains ambiguous directions (e.g. no directions — Use as Directed,||or - prn||), Network Pharmacy Provider must obtain more detailed directions so the days' supply can be calculated and the dosing scheduled submitted correctly. The directions may be obtained by direct communication with the Member or Prescriber. Documentation of such directions must be on the original Prescription.

Quantity

Network Pharmacy Providers must enter the quantity dispensed exactly as prescribed or if less than prescribed, as documented on the Prescription. The quantity dispensed must reflect the exact metric decimal quantity, without rounding. If the quantity to be dispensed is uncertain, Network Pharmacy Provider must contact the Prescriber to determine the appropriate amount to dispense and document said amount on the original, hard-copy Prescription. Network Pharmacy Provider should review Claim submission to be sure the quantity is accurate based on the specificity of the Drug Product and Prescriber instructions.

Additionally, Network Pharmacy Provider should adhere to the following:

- Network Pharmacy Provider shall not owe the Member a portion of the Prescription to be picked up at a later date and must only submit Claims what was actually dispensed (unless product expiration – such as reconstituted antibiotics used in prophylaxis);
- Network Pharmacy Provider shall use commercially reasonable efforts to ensure (i): the in-person fill time (ready for pickup) be no longer than forty (40) minutes, and (ii) a Prescription phoned in by a Prescriber is filled within ninety (90) minutes.
- If the minimum quantity as represented by the manufacturer's smallest available unit-of-use causes a rejection, with notation of a maximum days' supply, it is allowable to resubmit with the communicated days' supply which represents the plan maximum; and

- Claims submitted to Administrator in accordance with a Client Benefit Plan to allow limited dispensing of a non-covered Drug Product (e.g. three (3) day supply approved for a drug requiring a PA) may be dispensed with the smallest commercially available package size and submitted using the allowable days' supply.
- Network Pharmacy Provider shall, in accordance with 42 C.F.R. § 423.132, when dispensing a covered Medicare Part D Drug Product, inform the Medicare Part D beneficiary at the POS of the lowest-priced, generically equivalent version of that covered Medicare Part D Drug Product, if one exists for the beneficiary's Prescription.

Any subsequent changes in the original dispensing limitations (e.g. increase in quantity) or refill authorizations approved by the Prescriber must be documented on the original hard copy Prescription or in a readily retrievable electronic format acceptable by the State Board of Pharmacy in which Network Pharmacy Provider is located.

Refer to Section FWA for detailed information regarding standards and requirements for all Prescription records.

P. Collection of members cost-sharing amount

Network Pharmacy Provider must charge the Member the Cost-Sharing Amount indicated in the online response and only this amount. Waiving the amount associated with the Member Cost-Sharing is strictly prohibited, unless required by law and is considered a material breach of the Agreement.

Network Pharmacy Provider reimbursement pricing information, as well as prices paid to Network Pharmacy Provider for individual Claims under this Agreement are confidential and proprietary Administrator information and may not be disclosed on Member receipts or insurance profiles. The Network Pharmacy Provider may print U&C price and Member pay amount on the receipts, as well as the insurance profiles.

Network Pharmacy Provider agrees with the exception of (i) Cost-Sharing Amounts (ii) reasonable returned check costs and (iii) reasonable collection costs directly related to subparts (i) or (ii). Network Pharmacy Provider shall not in any event, including, without limitation, non-funding by Administrator or non-payment by a Client, insolvency of Administrator or a Client, or breach of this Agreement, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, hold responsible, or otherwise have any recourse against any Member, or any other person (other than the applicable Client) acting on behalf of any Member, or attempt to do any of the foregoing for any Prescription provided to any Member pursuant to the Agreement. This section shall survive expiration or termination of the Agreement.

Q. Claim reversals

Claims can be reversed up to thirty (30) calendar days after the submission date (or as specified by the plan); however when necessary, Claims should be reversed within fourteen (14) calendar days, as soon as reasonably practical or as specified by a particular governing requirement to assure Prescriptions with inaccurate information or those not dispensed to Members are credited in a timely fashion. All Prescriptions not received by a Member must be reversed within fourteen (14) calendar days from original submission.

Network Pharmacy Providers are responsible for ensuring all Covered Prescription Services are utilized by the Member (e.g. if a Drug Product is provided to a LTC Facility or Prescriber's office, the Network Pharmacy Provider must maintain an agreement that any unused Drug Product is returned to the Network Pharmacy Provider, in accordance with law, and/or Claims are reversed).

R. Prohibition on repackaging and reimportation

Network Pharmacy Provider shall not submit and Administrator is not responsible for payment for (i) Claims for Covered Prescription Services using a National Drug Code (NDC) for a repackaged drug or (ii) Claims for Covered Prescription Services filled using drugs imported or reimported into the United States (U.S.).

S. Use of third parties

Administrator may contract with third parties for Claims processing, eligibility, other duties or obligations Administrator is required to perform under the Agreement.

T. 340(B) program

To the extent Network Pharmacy Provider, during the term or any renewal term of the Agreement, is owned, operated or contracted with an eligible 340B Participating Entity to purchase outpatient Drug Products from drug manufacturers or wholesalers at reduced prices for use by eligible Members under the Public Health Service Act, Section 340(B) program, Network Pharmacy Provider shall immediately provide Administrator with written notice of such eligibility. The parties acknowledge/agree Administrator shall be entitled to modify the rates, fees, as well as other reimbursements offered to Network Pharmacy Provider hereunder in accordance with the PM and/or Agreement to the extent Network Pharmacy Provider becomes eligible to purchase Drug Products under the Public Health Service Act, Section 340(B) program. Failure of Network Pharmacy Provider to notify Administrator of its 340(B) eligibility as stated above shall constitute a material breach of the Agreement.

U. Hospice

Beneficiaries in hospice may receive a PA rejection for analgesics, antianxiety, antiemetics and laxatives to determine if the Claim should be covered under the hospice benefit, Medicare Part D benefit or fall under the beneficiary's liability. Rejected Claims return codes A3, 75, 569 and include a custom message with the phone number to begin the A3 Rejection Override review process.

Network Pharmacy Providers should work with hospice providers or Prescribers to obtain written documentation of Drug Products medically necessary, but unrelated to the terminal illness or related conditions. This written documentation should then be sent to the Benefit Plan Sponsor (or Administrator, if review has been delegated) for A3 Rejection Override review. If the Prescriber determines the Drug Product is covered under the hospice benefit, the Network Pharmacy Provider should submit the Claim to the hospice provider identified by the Prescriber. If the Prescriber is unable to make the determination, the Network Pharmacy Provider should provide the standardized pharmacy notice and advise the beneficiary or Prescriber to contact the Medicare Part D Sponsor at the telephone number in the secondary message to initiate the coverage determination request. Network Pharmacy Providers may also initiate an A3 Rejection override for Members who are no longer in hospice by submitting written documentation to the Benefit Plan Sponsor (or Administrator, if review has been delegated).

V. BIN information



A. OptumRx prescription bank identification numbers (RxBINs)

As of the date of publication of this PM, the following is a list of BIN numbers administered by Administrator. It is an all-inclusive list as of 10/9/2015 and is subject to change at any time. Please contact the Pharmacy Help Desk using the contact information provided in section II of this PM for more information.

610084	610094	610097	610127	610279	610494	610613
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OptumRx payer sheets

The Administrator D.O Payer sheets Related to Medicare Part D, Commercial and Medicaid are available on the health care professional's portal via the following:

<https://optumrx.com/RxsolHcpWeb/cmsContent.do?pageUrl=/HCP/HealthcareProviderTools/FormsAndDocuments>

B. Catamaran prescription bank identification numbers (RxBINs)

Non-Medicare

015558	003452	003650	003858	004469	004919	005757	005947	006524	007887
008878	008985	009117	010553	010876	011198	011297	011321	011677	011792
011867	012295	012502	012882	012924	012957	013907	014189	014211	014582
014681	014872	015383	015566	015756	015814	015921	016093	017933	060646
600471	601577	601683	603017	603286	606464	610011	610118	610140	610171
610182	610527	610560	610593	610619	610621	610652	610679	610704	610709
017010									

Medicare

610593	010868	610623	610011	015789	603286	016390	015764	013170	017010
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Catamaran payer sheets

The following elements from the Member ID card must be submitted for successful Claims adjudication:

- Member identification number
- Person Code (when printed on card)
- RxGRP (when printed on card)
- BIN/Processor Control Number

For additional payer-specific required data elements for the above RxBINs, please refer to the applicable legacy Catamaran Payer Specifications or catamaranrx.com/pharmacies (access to the portal will require proper credentials).

VI. Medicare product information and guidelines



A. Excluded drugs

As of the date of the printing of this PM, certain types of Drug Products or categories of Drug Products are not normally covered by MA-PD Benefit Plans. These Drug Products are not considered Medicare Part D (Part D) Drug Products and may be referred to as “exclusions” or “non-Part D Drug Products.”



The following are Drug Product classes or categories of Drug Products excluded from Part D coverage with examples of Drug Products within each class.

- Prescription vitamins and mineral products, with the exception of Formulary prenatal vitamins and fluoride preparations.
 - Examples: Ascorbic Acid, Folic Acid, Vitamin B
- Agents when used for anorexia, weight loss, or weight gain.
 - Examples: Ionamin, Meridia, Phentermine
- Agents when used to promote fertility.
 - Examples: Clomiphene Citrate, Fertinex, Follistim, Gonal-F, Serophene
- Agents when used for cosmetic purposes or hair growth.
 - Examples: Botox Cosmetic, Eldoquin, Hydroquinone, Lustra, Propecia, Renova
- Agents when used for the symptomatic relief of cough and colds.
 - Examples: Benzonatate, Tessalon
- Nonprescription or over-the-counter (OTC) drugs (with the exception of Insulin and associated medical supplies).
 - Examples: Aspirin, Sudafed, Tylenol
- Less-Than-Effective Medicaid Drug Efficacy Study Implementation (DESI) Drug Products.
 - Examples: Anucort HC, Tigan Suppositories
- Agents when used for the treatment of sexual or erectile dysfunction.
 - Examples: Viagra, Cialis, Levitra and Caverject
- Outpatient Drug Products for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
- End-Stage Renal Disease (ESRD) agents furnished to ESRD patients on dialysis.
 - Examples: Iron, calcitriol, doxercalciferol
- Agents without New Drug Application (NDA) or Abbreviated New Drug Application (ANDA) with the FDA.
- Any brand agent for which the manufacturer has not agreed to participate in the 50% gap discount program (i.e. labeler code agreement).
- Drug Products related to terminal illness furnished to Hospice patients.
 - Examples: analgesics, anti-anxiety drugs (anxiolytics), antiemetics and laxatives
- Compounded Drugs that contain at least one ingredient covered under Medicare Part B.
- Bulk ingredients/powders used in Compounded Drugs.

- Self-administered oral anti-cancer agents with the same active ingredients and indications as chemotherapy agents administered as incident to a Prescriber's professional service.

— Examples: Temodar, Xeloda



Many of the Benefit Plans the Administrator support may cover Medicare Part D-excluded Drug Products through additional separate coverage.

For more information, please contact customer service at the phone number provided on the back of the Member's ID card.

B. Medicare Part A/B/D coordination of benefits (COB)

Some Drug Products may be billed to either the Medicare Part A (if a Member is an inpatient), Part B or Part D benefit, depending on the intended use and other factors. Drug Products may be covered in one (1) of three (3) ways:

- Under Medicare Part A if Member is an inpatient or has elected Hospice; or
- Under Medicare Part B; or
- The MA-PD in conjunction with Medicare Part D.

Drug Products will never be covered through Medicare Parts A, B and the Medicare Part D PDP at the same time.

Online messaging (e.g. "COVERED UNDER PART B, BILL MEDICARE") is provided at the point of service.

When it is not clear which coverage applies, the prior authorization process should be initiated in order to determine the appropriate coverage.

MA-PD Plan Claim responses will have benefit stage qualifier values that have been approved through the NCPDP External Code List (ECL) process. These qualifier values will allow pharmacies to identify Medicare MA-PD Plans that offer additional benefits besides Part D covered Drug Products:

- The Medicare Advantage (MA) portion of the MA-PD Plan = Benefit Stage Qualifier (393-MV) value of "50" (Not paid under Part D, paid under Part C benefit (for MA-PD Plan)).
- Employer Group Waiver Plans (EGWPs) and supplement plans where Part D and non-Part D supplemental benefits are co-administered = Benefit Stage Qualifier (393-MV) value of "60" (Not paid under Part D, paid as or under a supplemental benefit only).
- Part D Drug Product not paid by Part D Benefit Plan, paid as or under a co-administered benefit only = BSQ (393-MV) value of "61".
- Non-Part D / Non-qualified Drug Product not paid by Part D Benefit Plan, paid as or under a co-administered benefit only = BSQ (393-MV) value of "62"
- Negotiated Price Non-Formulary Part D Drug Product = Benefit Stage Qualifier (393-MV) value of "70" (Part D Drug Product not paid by Part D Benefit Plan, paid by the beneficiary under Benefit Plan negotiated pricing).
- Negotiated Price Non-Part D Drug Product = Benefit Stage Qualifier (393-MV) value of "80" (Non-Part D Drug Product not paid by Part D Benefit Plan, paid by the beneficiary under Benefit Plan negotiated pricing).
- Enhanced or OTC drug not applicable to the Part D Drug Product spend, but is covered by the Part D Benefit Plan = BSQ (393-MV) value of "90".

These benefit stage qualifiers are not applicable to standalone MA Benefit Plans and PDP Benefit Plans, these plans will have separate 4Rx since they may be sold independently (a beneficiary can choose to use a MA product from one Medicare sponsor and a PDP product from another Medicare sponsor).

C. Medicare Part D clean claim determination

All Claims submitted by Pharmacies for Medicare Part D Drug Products are submitted by Medicare Part D Sponsor to CMS as Prescription Drug Events (PDE). In the event that CMS rejects or retro-actively denies a PDE because the PDE is not consistent with CMS instructions, guidance, regulations or applicable law, the underlying Claim may be deemed not a Clean Claim and such Claim may be reversed by Administrator on behalf of Medicare Part D Sponsor. In addition, if a Medicare Part D Sponsor's PDE is not accepted by CMS due to any fault by a Network Pharmacy Provider, Administrator shall have the right to recoupment from the Network Pharmacy Provider.

 For example, including the following but not limited to, per section 1927(k)(2) of the Social Security Act and 21 USC 535, to be covered under Medicare Part D, Drug Products must be dispensed only upon a Prescription of a health care provider who has the authority to prescribe Drug Products. Accordingly, PDE records submitted to CMS by a Medicare Part D Sponsor that were derived from Prescriptions by an unauthorized individual are not Clean Claims for payment and may be rejected or reversed by Administrator on behalf of Medicare Part D Sponsor in accordance with CMS instructions, guidance, regulations, or applicable law.

D. Medicare Part D coverage determination

Coverage determinations are requests to provide coverage for Drug Product under the Part D benefit. Exception requests are a specific type of coverage determination to waive coverage restrictions or limits applied through PA, step-therapy, quantity limits and Medicare Part A/B/Part D COB. The Member, Member's authorized representative, Prescriber or other authorized Prescriber may request a covered determination.

If the Medicare Part D Sponsor approves a coverage determination exception request, the approval is valid for the remainder of the plan year, unless clinically inappropriate or unnecessary, so long as the Prescriber continues to prescribe the Drug Product and it continues to be clinically appropriate and necessary, safe and effective for treating the Member's condition. If the exception request results in an adverse coverage determination, a Member may appeal the decision by calling the Customer Service number listed on his or her Member ID card or may follow appeals process as provided in the coverage determination notice of denial.

E. Permissible prescriber identifiers for Medicare Part D claims

For Medicare Part D and Medicaid Claims:

- Network Pharmacy Providers should submit a Prescriber NPI on all Part D and Medicaid Claim submissions. Claim submissions without a Prescriber ID will result in a Claim rejection with code 'EZ — Missing/Invalid Prescriber ID.
- Organizational NPIs should not be submitted.
- NPI should be submitted using an individual NPI that is valid on the Date of Service (DOS) for the Claim. Claims submitted without a valid individual Prescriber NPI will reject with NCPDP Rejection Code 619 — Prescriber Type 1 NPI Required, or 56 — "NPI EXISTS. PRESCRIBER ID INVALID/NOT ALLOWED" and the corresponding NPI number will be provided for use when resubmitting the Claim.
- Prescribers with a current exclusion list sanction (i.e. Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE), as well as General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS)) will be rejected.
- Prescriptions written for controlled substances: Administrator will reject Claims where the Prescriber being submitted on the Claim does not have the authority to write for the schedule Drug Product being prescribed.



Additionally, it is critical that you enter the correct Prescriber DEA and NPI numbers because Administrator sends correspondence (such as the Clinical Programs described in Section I below) to providers based on pharmacy Claims. Providing incorrect provider information can lead to privacy incidents and endanger Member safety.

F. Coverage determination timeframes

Standard coverage determination

Provided within seventy-two (72) hours of receipt of the request or for an exceptions request 72 hours after receipt of the Prescriber supporting statement. If the Medicare Part D Sponsor has not provided an answer within 72 hours after receiving a request, or, for an exceptions request, 72 hours after receipt of the Prescriber's supporting statement, the request will be automatically forwarded to an independent organization called an Independent Review Entity (IRE) for review.

Expedited coverage determination

Provided no later than twenty-four (24) hours of receipt of the request, or, for an exceptions request, 24 hours after receipt of the Prescriber's supporting statement. If the Medicare Part D Sponsor has not provided an answer within 24 hours after receiving a request, or, for an exceptions request, 24 hours after receipt of the Prescriber's supporting statement, the request will be automatically forwarded to an independent organization called an Independent Review Entity (IRE) for review.

G. Claim adjustments

Members are responsible for applicable Cost Sharing Amounts associated with their Benefit Plans. Medicare Part D Claim adjustments:

- Network Pharmacy Providers will be unable to reverse Medicare Part D Claims that have been reprocessed internally by Administrator. This is necessary because Claim adjustments have been made and if a financial adjustment was owed to the Member or LTC pharmacy, then a reimbursement process has already been initiated. Pharmacies attempting to submit reversal requests on Claims that have been reprocessed by Administrator will receive a NCPDP Rejection stating — "CLAIM NOT ELIGIBLE FOR REVERSAL. CONTACT HELP DESK FOR ASSISTANCE".
- If there is a need to resubmit Claims due to incorrect Medicare Part D Low Income Subsidy (LIS) level, please contact customer service.

H. Coverage limitations

A Drug Product is part of Medicare Part D only if it is for a medically accepted indication as defined in the Medicare regulations and implementing guidance. This definition includes prescribed uses supported by a citation included, or approved for inclusion, in one (1) of the following four (4) compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia Drug Information or its successor publication
- DRUGDEX Information System
- National Comprehensive Cancer Network (NCCN)

Based on this regulatory definition, indications supported in peer reviewed medical literature are not “medically accepted” if they are not yet included, or approved for inclusion, in one of the compendia. Therefore, the use of a Drug Product for such indications would not meet the definition of a Medicare Part D Drug Product and the Drug Product would not be a Covered Prescription Service under the Benefit Plan, even if the Member’s Prescriber states that the Drug Product is medically necessary.

The following additional coverage limitations may apply:

- Early refills for lost, stolen or destroyed Drug Products are not covered except during a declared “National Emergency.”
- Early refills for vacation supplies may be limited to a one (1) time fill of up to thirty-one (31) days per calendar year according to Benefit Plan.
- Drug Products will not be covered if prescribed by Prescribers that are excluded from Medicare program participation (unless they have an approved waiver on file with the OIG. These occurrences are very rare).
- A Member may refill most Prescriptions when a minimum of seventy-five percent (75%) of the quantity is consumed based on the number of days supplied. This minimum quantity consumed amount is seventy percent (70%) for eye drops.

I. Medication therapy management program (MTMP)

Consistent with the Medicare Modernization Act (MMA) requirements for MTMP, the Benefit Plan provides an MTMP for eligible plan Members at no additional cost to the Members. This program is designed to ensure that Members get the most medically appropriate, safe and cost effective Drug Products. It focuses on improving Drug Product use and reducing adverse Drug Product events.

MTMP eligibility

CMS requires that MTMP be offered to Members who have multiple chronic diseases, take multiple chronic/maintenance Medicare Part D covered Drug Products, and are likely to incur annual costs of \$3,507 for covered Medicare Part D Drug Products. Each plan is to define the number and type of chronic diseases and number of Medicare Part D Drug Products to include in the MTMP.

The criteria selected for the Administrator MTMP are as follows:

1. Member must have at least three (3) of the following target chronic diseases:
 - a. Hypertension
 - b. Chronic heart failure
 - c. Diabetes
 - d. Dyslipidemia
 - e. Osteoporosis or Rheumatoid arthritis (targeted disease is plan specific)
2. Member must have filled Prescriptions for at least eight (8) distinct Medicare Part D covered chronic/maintenance Drug Products during the identification period.
3. Member must be identified as likely to incur annual costs of \$3,507 for Medicare Part D covered Drug Products.

The Benefit Plan identifies and invites Medicare Part D Members who meet the criteria to take part in the MTMP.

Scope of MTMP services

The scope of the MTMP services is determined by each Medicare Part D Benefit Plan. In selecting MTMP services, Administrator complies with all CMS regulations and also considers the potential impact of each service on maximizing therapeutic outcomes. Therefore, the selected services exemplify the best practices stated in the MMA and can potentially impact clinical outcomes. The MTMP includes, but is not limited to:

- Providing patient and Prescriber education.
- Performing an annual comprehensive medication review (CMR) which consists of an interactive, person-to-person consultation with a pharmacist.
- Providing an individualized written summary with action plan and recommendations.
- Performing quarterly targeted Drug Product reviews on an ongoing basis.

MTMP enrollment process

The MTM Program is offered at no cost to qualifying Medicare Part D Members. Members who do not want to participate may opt out of the entire MTMP or any of its components. Administrator reviews the available medical and pharmacy Claims data to determine MTMP eligibility. In the absence of medical Claims data, a Drug Product proxy tool may be used for verification of diagnosis.

MTMP reimbursement for network pharmacy providers

As of the date of the publication of this PM, Administrator is solely responsible for designing, developing and implementing MTMP-related clinical services on behalf of its Clients and Benefit Plan Sponsors. Therefore, there are no plans for reimbursement to Network Pharmacy Providers at this time.

J. Medicare Part D transition policy

At the time an individual joins a Medicare Part D plan, a new Member may be taking a Drug Product that is either not on the Benefit Plan's Formulary or is subject to Benefit Plan requirements or restrictions.

The Member may be eligible to receive a temporary transition supply of the Drug Product. The maximum days' supply allowed is a thirty-one (31) day supply (unless the Prescription was written for fewer days) at any time during the first ninety (90) days of Membership in the Member's Medicare Part D Plan.

The Medicare Part D Sponsor provides notice to its Members and their Prescriber who receive a transitional supply of a Drug Product. This notice is sent by U.S. mail within three (3) business days of the temporary fill. It includes:

- An explanation of the temporary nature of the transitional supply.
- Instructions for working with the Benefit Plan Sponsor and the Prescriber to identify appropriate Formulary alternatives.
- An explanation of the Member's right to request an exception.
- A description of the procedures for requesting an exception.

Network Pharmacy Providers receives an electronic notice of a temporary transition fill via the POS System. If the exception is approved, the Member will be able to obtain the Drug Product for a specified period of time.

After the initial temporary transition supply of up to thirty-one (31) days, the Benefit Plan Sponsor may not continue to pay for these Drug Products under the transition policy. The Member should discuss appropriate alternative therapies on the Formulary with the Prescriber. If there are no alternatives, the Member and Prescriber may request a PA.

There may be unplanned transitions such as hospital discharges or level-of-care changes. If the Member is prescribed a Drug Product that is not on the Formulary or the ability to get a Drug Product is limited, the Member may request a level-of care transition supply of up to thirty-one (31) days (unless the Prescription is written for fewer days) for each level of care change to allow time to discuss alternative treatments with his or her Prescriber or to pursue a PA.

K. Medicare Part D transitioning long-term-care (LTC) facility residents

If the Member is a resident of a LTC facility, the Medicare Part D Sponsor will also cover a temporary transition supply. The maximum days' supply allowed is a thirty-one (31) day supply (unless the Prescription was written for fewer days) with refills prescribed; for up to a ninety-eight (98) day supply (unless the Prescription is written for fewer days) during the first ninety (90) days the individual is a Member of the Medicare Part D Benefit Plan.

If the Member needs a Drug Product that is not on the Formulary or the Member's ability to get the Drug Product is limited, but the individual has been a Member of the Plan for more than ninety (90) days, the Plan may cover a one (1) time, thirty-one (31) day supply of that Drug Product (unless the Prescription was written for fewer days) or an extension of the transition period while the Member pursues a PA.

There may be unplanned transitions such as hospital discharges or level-of-care changes. If the Member is prescribed a Drug Product that is not on the Formulary or the ability to get a Drug Product is limited, the Member may request a level-of care transition supply of up to thirty-one (31) days (unless the Prescription is written for fewer days) for each level of care change to allow time to discuss alternative treatments with his or her Prescriber or to pursue a PA.

L. LTC facility information to be provided upon termination

When a Network Pharmacy Provider no longer participates in the Administrator Pharmacy Network, including, but not limited to, a voluntary or involuntary termination, Network Pharmacy Provider shall comply with the Benefit Plan Sponsors transition of care policies and procedures. Within five (5) business days of the termination notice and upon request thereafter, Network Pharmacy Provider shall provide to Administrator a list of LTC facilities to which Network Pharmacy Provider provides services for Members receiving Part D benefits through the Medicare Part D Sponsor. The list shall contain i) Pharmacy Information, including Pharmacy Name, Pharmacy NCPDP #, Pharmacy Address, LTC Facility Name, LTC Facility Address and LTC Facility Phone Number and ii) a Member list by Facility, including each Member's Name, ID# and DOB.

M. Short-cycle-dispensing (SCD) processing for LTC

CMS issued a final rule that calls for the dispensing of Brand Name Drugs in fourteen (14) days or less increments to Medicare Part D Members residing in LTC facilities.

LTC Pharmacies may **bill** a short cycle claim for greater than a 14 day supply. However, you must **dispense** a short cycle prescription with a 14 day supply or less.

The ruling seeks to reduce Waste by minimizing unused Drug Products for the Medicare Part D program. Solid oral dosage Brand Name Drug is the only formulations affected by this ruling. Antibiotics in all forms, prepackaged Drug Products and liquid Drug Product formulations are exempt.

Member Cost-Sharing Amounts will be prorated based on the day supply.

 For example, if the Member has a \$30 copay for a 30-day supply, the Member will pay \$14 for a fourteen (14) day supply.

 When submitting Claims that are subject to the short-cycle regulations, providers must ensure that all of the following fields are submitted:

NCPDP field name	NCPDP field ID	Appropriate value for SCD claims
Patient residence	384-4X	03
Submission clarification code	354-NX	See below
Special packaging indicator	429-DT	See below

Valid submission clarification code and special packaging indicator combinations

NCPDP field name (SCC1)	NCPDP field ID (SCC2)	Appropriate value for SCD claims (SPI)	Outcome
14	22-29	1-8	Processed
14	33-35	1-8	Processed
15	22-29	1-8	Processed
15	33-35	1-8	Processed
16		1-8	Processed
16	18	1-8	Processed
16	22-29	1-8	Processed
16	32	2-8	Processed
16	33-35	1-8	Processed
17	22-29	1-8	Processed
17	32	2-8	Processed
17	33-35	1-8	Processed
18	16	1	Processed
18	22	1-8	Processed
18	23-35	1-8	Processed
22		1-8	Processed
22	18	1-8	Processed
23		1-8	Processed
23	18	1-8	Processed
24		1-8	Processed

24	18	1-8	Processed
25		1-8	Processed
25	18	1-8	Processed
26		1-8	Processed
26	18	1-8	Processed
27		1-8	Processed
27	18	1-8	Processed
28		1-8	Processed
28	18	1-8	Processed
29		1-8	Processed
29	18	1-8	Processed
30		6-8	Processed
30	18	6-8	Processed
31		6-8	Processed
31	18	6-8	Processed
32		2-8	Processed
32	18	2-8	Processed
33		1-8	Processed
33	18	1-8	Processed
34		1-8	Processed
34	18	1-8	Processed
35		1-8	Processed
35	18	1-8	Processed

Claims submitted with an invalid clarification code and special package indicator combination will be rejected with one of the following codes:

- 597 — LTC dispensing type does not support packaging type
- 613 — The packaging methodology or dispensing frequency is missing or inappropriate for LTC short-cycle

The following fields must be completed on the Claim submission form:

- Patient qualification — **patient residence**
- Claim qualification — **submission clarification code, special packaging type**

The combination of values for these Claim qualifications are defined by CMS and the National Council for Prescription Drug Programs (NCPDP) and are not user-definable. If an NCPDP defined combination is not submitted correctly by the pharmacy, the Claim will be rejected with the 613 code.

If the LTC has submitted the Claim according to the above guidelines and receives a 597 code, then the LTC may resubmit the Claim with Submission Clarification Code 21 and SPI 1 or 3 to bypass the edit.

N. Daily cost share (DCS)



Network Pharmacy Providers will be responsible for costs associated with erroneously submitted Claims. Incorrect and erroneously submitted Claims are not Clean Claims.

Claims submitted with an invalid clarification code and special package indication combination, including leaving both fields blank, will be rejected with one of the following clarification codes for DCS for this year:

- 47: Overrides Refill Too Soon for prorated Claims.
- 48: Overrides the next Claim after the prorated Claim that has a shortened supply to less days because of the prior Claim.

This change is in response to CMS requirement pursuant to 42 CFR section 423.153(b)(4)(i) that Medicare Part D Sponsors apply a daily Cost-Sharing rate when certain Prescriptions are dispensed by a network pharmacy for less than a 30-day supply.

As a result, Medicare Part D Sponsors will be able to apply a lower, prorated Cost-Sharing amount when the Prescription is dispensed, which may:

- Lower costs to patients for trial fills for less than 30 days.
- Facilitate synchronization of Prescriptions through reduced cost sharing.
- Reduce instances of unused Covered Prescription Services.

DCS requirement applies to the first fills/refill synch and any fill of less than one month, unless the Drug Product is one of the following exempt Drug Products:

- Antibiotics and Drug Products dispensed in their original container as indicated in the FDA prescribing information.
- Drug Products dispensed in their original packaging to help patients with compliance.

O. Medicare Part D sixty (60) day negative formulary change notice

Notice of Negative Formulary changes will be available online and disseminated periodically through Faxblast Communication to Network Pharmacy Providers sixty (60) days prior to the removal or adverse change in the preferred or tiered Cost-Sharing status of a Medicare Part D drug. In certain cases for FDA market withdrawals, the notice may or may not be retrospective. The posting will include:

- The name of the affected covered Medicare Part D Drug Product.
- Information on whether the covered Medicare Part D Drug Product is being removed from the Formulary, or adversely changing its preferred or tiered Cost-Sharing status.
- The reason why the covered Medicare Part D Drug Product is being removed from the Formulary, or changing its preferred or tiered Cost-Sharing status.
- Alternative Drug Product in the same therapeutic category, class or Cost-Sharing tier, and the expected cost sharing for that Drug Product. The means by which Members may obtain an updated coverage determination or an exception to a coverage determination.

Affected Members will also be notified in the Explanation of Benefits (EOB) about a Formulary change sixty (60) days before it takes effect.

P. Medicare Part D annual notice of change for continuing members

Each fall, Members receive an Annual Notice of Change (ANOC) packet from their Medicare Part D Sponsor. Packet materials identify changes in the benefit for the coming year. Changes explained in the packet become effective January 1 and will apply through December 31 of the upcoming plan year.

A Member may notice that a Formulary Drug Product he or she is currently taking is either not on the upcoming year's Formulary, Cost-Sharing has changed, or coverage is limited in the upcoming year.

If the Member is unable to transition to another product prior to the new benefit year, the Member will be entitled to a one (1) time transition fill during the first ninety (90) days of the new benefit year.

Q. Best available evidence (BAE)

All pharmacy types EXCLUDING LTC providers

If a Member questions their Cost-Sharing Amount, or states they qualify for federal subsidy or "extra help," they must have valid supporting documentation in order to receive the lower Cost-Sharing Amount. Any of the following documents are acceptable and meet the criteria as Best Available Evidence (BAE) to support a Member's qualification for federal subsidy:

- A copy of the beneficiary's Medicaid card that includes the beneficiary's name and eligibility date status during a month which occurred after June 30 of the previous calendar year;
- A copy of a State document that confirms active Medicaid status during a month which occurred after June 30 of the previous calendar year;
- A printed document from the State electronic enrollment file showing Medicaid status during a month which occurred after June 30 of the previous calendar year;
- A screen print from the State's Medicaid systems showing Medicaid status during a month which occurred after June 30 of the previous calendar year;
- Other documentation provided by the State or CMS showing Medicaid status during a month which occurred after June 30 of the previous calendar year;
- A copy of the Social Security Administration (SSA) award letter for those individuals who are not deemed eligible, but who apply for and are found to be Low Income Subsidy ("LIS") eligible.



To correct a Member's subsidy level utilizing BAE, please secure one (1) of the above documents from the Member and contact Customer Service at the phone number provided on the back of the Member's ID card.

- Provided the documentation received meets the BAE criteria, the Member's Cost-Sharing Amounts will be adjusted within forty-eight (48) to seventy-two (72) hours of receipt of BAE documentation.
- Reprocess the Prescription(s) to capture the lower copayment amount.
- If you have any questions on BAE, please contact Customer Service at the phone number provided on the back of the Member's ID card.

LTC providers ONLY

If a Member questions their Cost-Sharing Amount, or states that they qualify for the institutional status zero (0) cost sharing, they must have valid documentation supporting this position in order to receive the zero (0) copayment amount. Any of the following documents are acceptable and meet the criteria as Best Available Evidence (BAE) supporting a Member's institutional status and qualification for zero (0) cost sharing:

- A remittance from the facility showing Medicaid payment for a full calendar month for the beneficiary during a month after June 30 of the previous calendar year;
- A copy of the state document that confirms Medicaid payment for a full calendar month for the beneficiary during a month after June 30 of the previous calendar year;
- A screen print from the State's Medicaid systems showing the beneficiary's institutional status for at least a full calendar month stay for Medicaid payment purposes during a month after June 30 of the previous calendar year.

To correct a Member's subsidy level utilizing BAE, please secure one (1) of the above documents from the Member and contact Customer Service at the phone number provided on the back of the Member's ID card.



- Provided that the documentation received meets the BAE criteria, the Member's copayment will be adjusted within forty-eight (48) to seventy-two (72) hours of receipt of BAE documentation.
- Reprocess the Prescription(s) to capture the lower copayment amount.
- If you have any questions on BAE, please contact Customer Service at the phone number provided on the back of the ID card.

R. Part D mail order, home delivery or other automatic delivery program

Initial/New Prescriptions

CMS guidance states that Network Pharmacy Providers who are contracted to offer Mail order, home delivery or other automatic delivery programs are required to obtain Member or authorized representative consent prior to delivery if the Prescription was electronically transmitted (i.e. by fax or electronic Prescription) directly to the Pharmacy and if the Member has not had previous Mail order, home delivery or automatic shipment experience with that Pharmacy. If the Member has experience using Mail order or other automatic delivery programs at the Pharmacy, they do not need to establish additional consent.

Any paper Prescription submitted by the Member or authorized representative to the Pharmacy means the Member is electing to have the Prescription order(s) filled at the Pharmacy, so separate consent is not required. In other words, the act of submitting or Mailing a Prescription by the Member or authorized representative demonstrates consent.

Network Pharmacy Providers are required to maintain documentation showing the Member or authorized representative consent to fill the Prescription or a history of previous Mail order, home delivery or automatic shipment experience with the Pharmacy. This documentation should be made available to the Administrator or Medicare Part D Sponsor upon request.

Refill Prescriptions

CMS guidance states that Network Pharmacy Providers who are contracted to offer Mail Order or home delivery programs need to obtain Member consent prior to shipping Prescriptions when the Member or their authorized representative did not initiate the request (e.g. Prescriptions faxed by the Prescriber, electronic Prescriptions or refills prompted by auto-fill systems). The Pharmacy does not need to obtain consent to deliver a Prescription or refill which was prompted by the Member.

Network Pharmacy Providers are required to maintain documentation showing the Member or authorized representative consent to fill the Prescription or a history of previous Mail Order or home delivery experience with the Pharmacy. This documentation should be made available to the Administrator or Medicare Part D Sponsor upon request.

S. Qualified medicare beneficiary coverage — coordination of benefits (COB) for Part B drugs

Network Pharmacy Providers are required by CMS regulations to coordinate benefits with any secondary plan for dual-eligible Qualified Medicare Beneficiaries (QMB). QMB Members with Medicare Advantage-Prescription Drug programs are eligible to have any coinsurance for Part B Drug Products and supplies coordinated with their secondary plan (e.g. a state Medicaid plan) when secondary benefit information is presented to the Network Pharmacy Provider by the QMB Member. Upon knowledge, Network Pharmacy Providers are required by CMS to coordinate benefits with any secondary coverage even if such secondary coverage does not allow processing via a POS System. The Network Pharmacy Provider should be billing the balance due to Medicaid as a secondary payer, as Medicaid should cover all Part B cost sharing for QMB Members. If the Network Pharmacy Provider cannot successfully bill Medicaid or is getting a rejection from Medicaid for any reason, the Network Pharmacy Provider is required by CMS guidelines to dispense the Part B Drug Product/supply and not collect any cost sharing from the QMB Member. Network Pharmacy Providers may be allowed to submit claims to the applicable Medicaid program via paper if electronic submission is not applicable.

CMS language on this issue: <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticles/downloads/se1128.pdf>

Excerpt: “All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare Cost-Sharing. This includes deductible, coinsurance, and copayments, known as “balance billing.” Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost sharing. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare Cost-Sharing are subject to sanctions.”

T. Medicare supplier number

Administrator encourages Network Pharmacy Provider to obtain and maintain for each Pharmacy a Medicare Part B supplier number pursuant to 42 CFR § 424.57. Network Pharmacy Provider agrees to inform Administrator of the Medicare Part B supplier number assigned to those Pharmacies which have obtained such supplier numbers from CMS for record-keeping-purposes and to identify those Pharmacies as having Medicare Part B supplier numbers in the pharmacy network directories maintained by or on behalf of Administrator’s Clients.

U. Medicare notice of patients rights

Network Pharmacy Provider must comply with all CMS regulations regarding the provision of written notices to Medicare Members. To demonstrate compliance, Network Pharmacy Provider must:

Demonstrate and provide documentation to detail the process by which each Member receives the communication entitled Notice of Patient Rights (CMS document 10147) during each rejection (rejection type 569); Display the sign in the Network Pharmacy Provider waiting area or distributing to a new Member does NOT meet the requirement; If a Member is not physically present at the time the rejection has occurred, the Member must be notified of the Claim rejection and the Medicare Notice of Rights is available to them at the Pharmacy or can be mailed to the Member; Active work on a rejection, such as working with the Prescriber for Drug Product change or coverage such as a PA, does NOT remove the requirement to provide the notice. The Member should still be supplied the notice with information on any actions the Network Pharmacy Provider is taking.

V. Compliance

All Medicare Advantage Organizations, Medicare Part D Sponsors, MMP and Medicaid Managed Care Organizations are required to have a compliance plan which meets regulatory requirements (Chapter 42 of the CRF, Parts 422 and 423). It must be reasonably designed, implemented, enforced so that it generally will be effective in preventing and detecting noncompliance with regulatory requirements, including program-specific (for example Medicare Part D) requirements, as well as preventing, detecting potential criminal or fraudulent conduct. Administrator has a compliance plan in place which is in alignment with Federal Sentencing Guidelines among other things, supports the monitoring and detection of FWA within federal programs.

Administrator, our Client Medicare Advantage Organizations, Medicare Part D Sponsors, MMP and Medicaid Managed Care Organization Compliance Plans include the following recommended elements around which our program has been built:

1. **Written policies and procedures:** Standards of conduct to assist employees, independent contractors, as well as agents to comply with applicable laws, including Medicare and Medicaid.
2. **Compliance officer/compliance committee:** Designation of a compliance officer and compliance committee.
3. **Education and training:** Education and training programs for appropriate Network Pharmacy Providers employees which include among other things, the Network Pharmacy Provider's standards of conduct, as well as ethical and compliance expectations.
4. **Effective lines of communication:** A process to report violations of the standard of conduct.
5. **Monitoring and auditing:** A system to monitor and audit activities within the Network Pharmacy Provider for compliance with applicable laws.
6. **Enforcement and discipline:** A system to respond to allegations of violations of the standard of conduct and procedures to enforce appropriate disciplinary action against employees, independent contractors and agents who have violated the standards of conduct. In addition, the Network Pharmacy Provider must have a system to monitor whether employees, independent contractors, as well as agents have been sanctioned by the Medicare or Medicaid Programs upon hire and at least monthly. Network Pharmacy Providers should be aware Administrator and/or Benefit Plan Sponsors shall not pay for drugs provided by a Network Pharmacy Provider excluded by either the Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) or General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS) pursuant to 42 CFR § 1001.1901.

- a. Pharmacies must check these lists upon hire and at least monthly to ensure employees working with Medicare business have not been excluded from Federal program participation. Pharmacy staff can check these lists by using the following links:
 - i. OIG: <http://oig.hhs.gov/exclusions/index.asp>
 - ii. GSA: <https://sam.gov/index.html>

7. **Responding to detected offenses and developing corrective action initiatives:** A system to investigate allegations of noncompliant behavior by employees, independent contractors, or agents. Benefit Plan Sponsors, FDR entities (including Network Pharmacy Providers) should initiate an investigation immediately, but not later than two (2) weeks from the date that a potential fraud matter is identified. If, upon investigation, the Network Pharmacy Provider believes that potential misconduct has occurred, the Network Pharmacy Provider should report the alleged activity to the Administrator Pharmacy Help Desk using the contact information provided in Section II of this PM. In addition, the Network Pharmacy Provider may report this information to any of the following:
 - a. Customer services number identified on the back of a Member's ID card.
 - b. National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SAFERX or **(1-877-772-3379)**.

In addition, Administrator and Benefit Plan Sponsors monitor Network Pharmacy Providers who have been the subject of complaints, investigations, violations and prosecutions. Upon notification of potential issues, Administrator may request information regarding the corrective action initiatives implemented by the Network Pharmacy Provider to identify or prevent the identified misconduct from recurring.

1. **FWA:** Administrator has a zero-tolerance policy for FWA; will administer corrective action up to and including reclamation of the overpayments associated with FWA, and/or termination of the Agreement as warranted.
 - a. Network Pharmacy Providers must comply with all applicable laws and rules concerning compliance with federal/state requirements.
 - b. To obtain a copy of the CMS FWA and General Compliance Training Module (i.e. *Medicare Parts C and D FWA Training; Medicare Parts C and D General Compliance Training*) click the following:
<http://cms.hhs.gov/Outreach-and-Education/Medicare-Learning-MLN/MLNProducts/ProviderCompliance.html>
2. **Pharmacy provider marketing activity:** CMS has issued instruction, included in the Medicare Marketing Guidelines Manual, on provider marketing activities. CMS is concerned with a Network Pharmacy Provider marketing activities, because a Network Pharmacy Provider may not be fully aware of all Benefit Plans and Cost Sharing Amounts. This could lead to the perception a Network Pharmacy Provider is acting as an agent of the Benefit Plan Sponsor instead of as the Member's Network Pharmacy Provider and cause confusion for the Member. Since Network Pharmacy Providers may face conflicting incentives when acting as a Benefit Plan Sponsor representative, they are not permitted to specifically market any Benefit Plan.

To the extent that a Network Pharmacy Provider can assist a beneficiary in an objective assessment of his/her needs and potential options to meet those needs, they may do so. Therefore, a pharmacy may engage in discussions with beneficiaries, should a beneficiary seek advice. However, a pharmacy must remain neutral when assisting with enrollment decisions and may **NOT**:

- Offer sales/appointment forms.
- Prepare, accept or submit Medicare enrollment applications.
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of Benefit Plan Sponsors.

- Offer anything of value to induce plan enrollees to select them as their provider.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distribute materials/applications within an consultation area.

Network Pharmacy Providers **MAY:**

- Provide the names of Benefit Plan Sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials in common areas when made available to pharmacy.
- Refer their patients to other sources of information, such as:
 - State-Health Insurance Assistance Programs (SHIPs) plan marketing representatives
 - State Medicaid Office
 - Local Social Security Office
 - CMS website at <http://cms.hhs.gov/> or 1-800-MEDICARE **(1-800-633-42273)**
 - Share information with patients from CMS website, including the
 - Medicare and You Handbook or Medicare Options Compare (from medicare.gov); or
 - Other documents that were written by or previously approved by CMS

CMS complaints tracking module (CTM)

CMS communicates complaints from beneficiaries and providers via CTM to the Medicare Part D Sponsor; CMS expects these to be promptly acknowledged, investigated and resolved in accordance with applicable regulations/guidelines.

If a CTM regarding Network Pharmacy Provider is received, the Administrator will notify the individual Network Pharmacy Provider identified in the complaint. Network Pharmacy Providers are expected to provide an initial response to the complaint within twenty-four (24) hours and work to resolve completely within seven (7) calendar days. Failure to be compliant could result in corrective action and/or termination of the Agreement as warranted.

W. DUR medicare Part D therapeutic dose limits edits

The Administrator Therapeutic Dose Limits (THERDOSE) screening within the concurrent DUR program applies safety edits which minimize the risk of medication overutilization. The rules monitor for total daily medication use above the FDA approved maximum dosing across multiple claims at the ingredient level. Currently the Administrator standard includes Soft Rejects when a Member exceeds the acetaminophen maximum daily dose and returns messaging only for several other therapeutic categories. Administrator will also reject oral diabetes products (i.e. single ingredient and multiple ingredients) which exceeds the FDA approved maximum dosing in order to align with CMS' Patient Safety Monitoring program for these Drug Products. Pharmacies can override the soft reject to expedite successful adjudication of THERDOSE rejections (DUR Reject 88) at POS (point-of-sale).

DUR/PPS codes (reason, professional, and result codes):

Pharmacists should use their professional judgment to review and override a THERDOSE Soft Reject. The Pharmacist will need to identify and enter the appropriate DUR/PPS Reason, Professional, as well as the Result codes for each component. This information is then collected and used to respond to CMS' Acetaminophen Overutilization Monitoring Program cases and will also be used to review CMS Diabetes Medication Dosage Patient Safety Reports. If a Pharmacist receives this specific type of error (DUR Reject 88), the following steps should be followed.

1. Review the Member profile to identify why the Member is filling greater than the FDA approved maximum dose.
2. Consult with the appropriate clinicians and/or the Member as needed
3. Based on your clinical judgment, determine if the Drug Product should be dispensed
4. Determined appropriate, override the rejection by identifying and entering the appropriate Reason, Professional, and Result code for each component.
 - a. Reason code below should auto-populate; if not, then use the Reason Code below of HD (High Dose Alert).
 - b. Select the appropriate Professional and Result codes from the list provided below.
5. Each component is only allowed to have one code.

The pharmacist will need to identify and enter the appropriate DUR/PPS Reason, Professional, and Result codes for each component. Appropriate code options are provided in the following lists 1 and 2.

1. Reason for Service Code: HD High Dose Alert
2. Professional Code Values and Result Code Values:

Professional Codes	Description	Result Codes	Description
MO	Prescriber Consulted	1A	Filled As Is,False Positv
MO	Prescriber Consulted	1B	Filled Prescription As Is
MO	Prescriber Consulted	1C	Filled,Different Dose
MO	Prescriber Consulted	1D	Filled,Different Directns
MO	Prescriber Consulted	1F	Filled,Different Quantity
MO	Prescriber Consulted	2A	Prescription Not Filled
MO	Prescriber Consulted	3C	Discontinued Drug
MO	Prescriber Consulted	3D	Regimen Changed
MO	Prescriber Consulted	3E	Therapy Changed
PO	Patient Consulted	1A	Filled As Is,False Positv
PO	Patient Consulted	3K	Instructions Understood
RO	Pharmacist Consulted Othr	1A	Filled As Is,False Positv
RO	Pharmacist Consulted Othr	1B	Filled Prescription As Is
RO	Pharmacist Consulted Othr	1C	Filled,Different Dose
RO	Pharmacist Consulted Othr	1D	Filled,Different Directns

R0	Pharmacist Consulted Othr	1F	Filled,Different Quantity
R0	Pharmacist Consulted Othr	2A	Prescription Not Filled
R0	Pharmacist Consulted Othr	3C	Discontinued Drug
R0	Pharmacist Consulted Othr	3D	Regimen Changed
R0	Pharmacist Consulted Othr	3E	Therapy Changed

The following example illustrates the use of the DUR/PPS codes related to a THERDOSE edit reject:

- A Member presents a Prescription for hydrocodone/APAP (10/325mg) with a quantity = 100 and day supply = 10.
- The pharmacist attempts to process the claim and receives a 'DUR Reject 88' (THERDOSE).
- The pharmacist reviews the patient profile and discovers the member recently filled an oxycodone/APAP (5/325mg) Prescription with quantity = 60 and day supply = 15.
- The overlap of the 2 Prescriptions caused the THERDOSE edit to be triggered.
- The pharmacist consults with the prescriber and determines that the oxycodone/APAP product is being discontinued.
- The pharmacist then enters the appropriate Reason, Professional, and Result codes and then re-submits the claim.
- In this scenario, an appropriate combination would be as follows:
 - HD (High Dose Alert)
 - M0 (Prescriber Consulted)
 - 3C (Discontinued Drug)
- The entering of the above codes resolves the DUR Reject 88 for THERDOSE.

VII. Compliance; fraud, waste and abuse (FWA); audits



A. Network pharmacy provider FWA and general compliance training

You are required to report any suspected or potential FWA.

Network Pharmacy Providers with a legacy OptumRx Agreement:

 Report an incident, please contact the Pharmacy Network Relations Department at **1-800-613-3591** or via email to **pharmacyprograms@optum.com**.

Network Pharmacy Providers with a legacy Catamaran Agreement:

 Report an incident, please contact the FWA hotline toll-free number at **1-888-625-5685**, available any time, 24 hours a day, seven days a week.

Network Pharmacy Provider must notify Administrator if Network Pharmacy Provider has reason to believe potentially fraudulent Prescription or inappropriate Claims activity is occurring. Client(s) or Benefit Plan Sponsors, FDR entities (including Network Pharmacy Providers) should initiate an inquiry immediately, but no less than two (2) weeks from the date a potential fraud matter has been identified. If, upon investigation, the Network Pharmacy Provider believes a potential misconduct has occurred, the Network Pharmacy Provider may also report the alleged activity to any of the following:

- Customer service number identified on the back of a Member's ID card
- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)

 1-877-7SAFERX (1-877-772-3379)

Administrator actively investigates and refers fraudulent/abusive activity of any kind by any of its contracted Network Pharmacy Providers, associates, Members, vendors, contractors and/or other business entities. Administrator contracts with Clients and Benefit Plan Sponsors, some of which provide service to Medicare or Medicaid beneficiaries. These Clients are required by CMS to have a comprehensive plan to detect, correct and prevent FWA. Specifically, a Network Pharmacy Provider involved in providing services for Medicare Part D Members is responsible for implementing a program to control FWA and to facilitate compliance in the delivery of Covered Prescription Services through the Medicare benefit. Network Pharmacy Providers must cooperate and assist any federal/state agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected FWA.

Network Pharmacy Providers must provide original and/or copies of any and all information as requested by any such federal/state agency, allow access to premises, as well as provide records to any federal/state government unit or investigating agency, upon request (i.e. free-of-charge).

If Network Pharmacy Providers suspect any fraud and abuse by a member or Managed Care Organization (MCO), the Network Pharmacy Provider must report this to the applicable federal/state agency.

Please see the link below to review instructions for completing the training and complying with other compliance requirements.

<https://optumrx.com/RxsolHcpWeb/cmsContent.do?pageUrl=/HCP/HealthcareProviderTools/FraudWasteAndAbuse>



Completing the annual CMS FWA and general compliance training, as well as the online attestation, is required by your Administrator network contract and is your obligation as a recipient of Medicare Part D or any other government funds.

Common FWA schemes to avoid

Network Pharmacy Providers should be aware there are schemes perpetrated by Prescribers and Members.

 The following is a list of types of FWA which could be perpetrated by Prescribers. This is included for educational purposes only and is not an all-inclusive list:

- **Illegal remuneration schemes:** Prescriber or Member is offered, paid, solicited or receives unlawful remuneration to induce or reward them for inappropriate behavior. An example of an illegal remuneration scheme would be when a Prescriber receives something of value for writing Prescriptions for medically inappropriate or unnecessary drugs or products or to induce the Prescriber to prescribe certain Drug Products rather than others. Another example would be when a Network Pharmacy Provider waives a Member's Cost Sharing Amount to encourage their patronage.
- **Script mills:** Provider writes Prescriptions for Drug Products or Compounded Drugs that are not medically necessary, often in mass quantities, and often for patients that are not his or hers.
 - Member presenting a Prescription not written by the Prescriber identified;
 - Member presenting a forged or altered Prescription, calling in their own Prescriptions, over-utilizing Prescriptions, selling their Prescriptions or Membership information;
 - Drug Products inconsistent with the practice or specialty of a Prescriber;
 - Illegal remuneration schemes;
 - Prescriptions not medically necessary
 - Cash or other benefits to switch Drug Products to prescribe certain Drug Products.
- **Inappropriate relationships with health care provider:** Potentially inappropriate relationships between pharmaceutical manufacturers and Prescribers, such as "switching" arrangements to induce a Prescriber to switch the prescribed drug from a competing product; incentives offered to Prescriber to prescribe medically unnecessary drugs; consulting and advisory payments, payments for detailing, business courtesies and other gratuities, educational and research funding; improper entertainment or incentives offered by sales agents.
- **Illegal usage of free samples:** Providing free samples to Prescribers knowing and expecting those Prescribers to bill the federal health care programs for the samples.

 The following is a list of types of FWA which could be perpetrated by Members, including beneficiaries enrolled in the Medicare Part D Program. This is included for educational purposes only and is not an all-inclusive list:

- **Overutilization and drug-seeking members:** The number of persons admitting to Abuse of controlled substances has increased in the past decade. Abuse has risen dramatically in Prescription drugs.
- **Altered and forged Prescriptions:** Member alters the quantity and/or strength on a valid Prescription or illegally creates Prescriptions using stolen or forged Prescription pads or by other methods of FWA.
- **Pharmacy hopping and doctor shopping:** Members visit numerous doctors to obtain Prescriptions for Prescription drugs and/or controlled substances and visit numerous pharmacies to facilitate the filling of excessive quantities of Prescription drugs.
- **Prescription diversion and inappropriate use:** Members obtain Covered Prescription Services from a Network Pharmacy Provider and give or sell these Covered Prescription Services to someone else. This can also include the inappropriate consumption or distribution of a Member's Covered Prescription Services by a caregiver or anyone else.

- **Resale of drugs on black market:** Member falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.
- **Misrepresentation of status:** A Medicare Member misrepresents personal information, such as identity, eligibility or medical condition in order to illegally receive Medicare benefits.
- **Theft of prescriber identifiers:** Drug Enforcement Administration (DEA) number, Prescription pad, or e-prescriber authentication (login) information for creating fabricated Prescriptions.



The following is a list of types of FWA that could be perpetrated by a Network Pharmacy Provider and may result in audits, as well as sanctions including termination of participation in Administrator networks. This is included for educational purposes only and is not an all-inclusive list:

- **Billing for a Brand Name Drug and a dispensing a Generic Drug**
- **Billing of an NDC for other than what was dispensed**
- **Overbilling of quantity prescribed**
- **Billing multiple payers for the same Prescriptions**
- **Inappropriate billing of Compounded Drugs**
- **Submitting a dummy DEA/NPI or Invalid DEA/NPI numbers to obtain a paid response**
- **Billing for a Brand Name Drug with Dispense as Written per the Prescriber (DAW 1) when a Prescriber has not specified "Do Not Substitute" on the Prescription or other inappropriate use of DAW codes**
- **Billing for larger pack sizes when one smaller pack size will meet the directions of the Prescriber and remain within the Benefit Plan's maximum days' supply**
- **Billing for more fills or refills than were authorized**
- **Splitting Prescriptions into multiple Claims to obtain multiple dispensing fees or undermine a PA or quantity limits, etc.**
- **Billing for invalid Prescriptions due to lack of a legal Prescriber, forgery, or false or fictitious documents**
- **Dilution of Drug Product provided to Member/consumer**
- **Acquisitions of Prescription drugs on black market and black market sales**
- **Collusion with Prescriber, wholesaler or others and kickback schemes**
- **Pill shorting to Members/consumer**
 - Dispensing less than quantity billed
- **Selling the same Drug Product twice**
 - Recycling pills
- **LTC Network Pharmacy Provider billing for unused Covered Prescription Services and not applying credit to Member**
- **Inappropriate, inaccurate or incomplete record-keeping practices related to billed Prescriptions**
- **Prospective billing**
- **Prescription drug switching involves the billing for one drug but dispensing a different drug**

- **Phantom Claims billing where Network Pharmacy Provider submits Claims for Covered Prescription Services not provided**
- **Dispensing expired or adulterated Prescription Drug Products**
- **Forging or altering Prescriptions**
- **Refilling Prescriptions erroneously**
- **Billing for non-existent Prescriptions**
- **TrOOP manipulation**
- **Manipulation of quantity limits**

Network Pharmacy Provider FWA attestation

Network Pharmacy Providers are required to maintain proper policies and procedures related to training on Compliance, as well as FWA. Compliance and FWA training is an important component of Network Pharmacy Provider operations and is required to be completed upon initial hire, as well as annually for all federal/state/locally funded Benefit Plans. An important part of the Medicare, Medicaid and Medicare-Medicaid Enrollees (MME) programs are controlling FWA. For this reason, CMS requires all Medicare Advantage Organizations (MAOs), Medicare-Medicaid plans (MMPs), Medicare Part D plans (PDP), as well as Medicare Part D Sponsors require FWA and general compliance training with their FDR contracted entities, including but not limited to, Administrator and Network Pharmacy Providers. In addition, FDRs are required to monitor federal exclusions lists on at least on a monthly basis, as well as annually distribute code or standards of conduct information. State Medicaid agencies have made similar requirements of their Medicaid plans, including MME Plans.

Each year by December 31, Network Pharmacy Providers are required to electronically sign the CMS FWA Attestation to satisfy mandatory compliance requirements related to guidance from CMS. CMS has set forth expressed guidance within the Federal Register at Title 42 of the CFR, Parts 422 and 423 and other agency guidance requiring Medicare Advantage and Prescription Drug Medicare Part D Sponsor or their delegates, FDR entities to demonstrate compliance with the following:

1. Network Provider Pharmacy hereby verifies and certifies it has reviewed and conducted satisfactory annual FWA and general compliance training programs or has utilized the training program provided by CMS and also has provided staff with links to our Client(s) or Benefit Plan Sponsors Code of Conduct policies, which is located online at the following:

- **Network Pharmacy Providers participating in any of Administrator's Medicare Part D networks**
<https://optumrx.com/RxsolHcpWeb/cmsContent.do?pageUrl=/HCP/HealthcareProviderTools/FraudWasteAndAbuse>

In addition, Network Pharmacy Provider hereby attests to no exclusion from participation in federal health care programs by checking their status in the exclusion lists maintained by the Office of Inspector General (OIG) U.S. Department of Health and Human Services (HHS) and U.S. General Services Administration (GSA) System for Award Management (SAM). Network Pharmacy Provider has reviewed the OIG-HHS and GSA-SAM lists prior to hire/contracting and monthly thereafter for its current employees/contractors, health professionals or subcontracted delegates, working with Plan Sponsor programs to ensure none are excluded from participating in these programs.

This information is available at the following sites:

- Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) — <http://oig.hhs.gov/exclusions/index.asp>
- General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS) — <https://sam.gov/portal/SAM/#1>



Completing the annual CMS FWA and general compliance training, as well as the online attestation, is required by your Administrator's Agreement(s) and is your obligation as a recipient of Medicare Part D or any other government funds. CMS does not require that FDR entities adopt Client(s) or Benefit Plan Sponsors Code of Conduct policies, but that these sponsors distribute Code of Conduct policies to FDR contracting entities for the purposes of supporting CMS FWA and general compliance requirements.

As noted in the training materials, Network Pharmacy Provider must complete the CMS provided or other industry accepted FWA & General Compliance training module. This training must be completed by all employees within ninety (90) days of hire/contract and annually thereafter.

Please Note:

Beginning in 2016, use of the CMS training materials located on the Medicare Learning Network (MLN) is required and the content of these materials cannot be modified in order to ensure the integrity and completeness of the training.

A record of completion (i.e. training log) of the required CMS compliant FWA training for participating Network Pharmacy Providers should be maintained. Type of training, method, vendor, date, time should be noted and signoffs from the staff when required by Administrator, Clients or Benefit Plan Sponsors obtained. These logs must be maintained for a period of ten (10) years and made available immediately upon request to Administrator or Auditor in case of an audit, regulator request, etc.

It is not necessary to submit a copy of your training materials, training log, etc. to OptumRx Pharmacy Programs or Catamaran Provider Relations. You are only required to attest to the completion of annual training requirements, provide specific proof down to the employee/contractor level validating training was completed as per the provisions notated above and provide these documents annually, as well as upon request.

Non-compliance with this provision may result in remedies such as corrective actions or termination of the Network Pharmacy Provider from Administrator's networks. Unless agreed to by Administrator, a PSAO, must comply by providing a single attestation on behalf of its entire membership of Network Pharmacy Providers.

Should Network Pharmacy Providers not have access to the Internet, please feel free to contact OptumRx Pharmacy Programs or Catamaran Provider Relations to obtain additional information on how to maintain compliance.

You are required to report any suspected or potential FWA.

B. Pharmacy audits (Audits)

Audit policy statement

All Claims submitted to Administrator are subject to audit. The Administrator Pharmacy Audit Program helps to ensure Claims are submitted, dispensed in accordance with Administrator guidelines and the Network Pharmacy Provider complies with those guidelines, as well as the terms/conditions for participation in the applicable network.

The audit program also helps to protect against FWA.

Administrator or its authorized agent, governmental agencies or their representatives, (hereafter referred to as "Auditor"), shall have the right to audit Network Pharmacy Provider during normal business hours, typically with reasonable notice, fourteen (14) days to examine/audit the books, records, signature logs, files, equipment and their respective facilities of all Network Pharmacy Provider transactions which relate to any aspect of the performance of the Agreement including the transactions contemplated under the PM or Plan Specifications, as well as requirements set forth by Law. If Auditors are denied access to requested audit documents, 100% of the amount previously paid for the Claim(s) in issue becomes due immediately. Audits will be conducted in accordance with applicable laws and state regulatory guidelines.

Network Pharmacy Provider shall cooperate with Auditors and promptly provide access to all information or documents deemed necessary by Auditors. Auditors may reproduce any record at its own expense; however, no original copy may be removed from Network Pharmacy Provider's facilities. Auditor may report audit findings to Administrator's Clients, appropriate governmental entities, regulatory agencies and professional review and audit organizations.

The parties agree all audits will be conducted in accordance with applicable laws and any additional required language to be included in the Agreement or PM by such applicable laws shall be deemed included. During the term of the Agreement and for a period of five (5) years thereafter or in accordance with applicable law,

Audit purpose

The purpose of the Administrator policy is:

1. To *validate* and photograph, if necessary, any and/or all of the following:
 - a. Accuracy of paid Claims, contractual compliance, regulatory compliance, various aspects of Drug Product inventories, presence of required signage and/or documentation; and/or
2. To *observe* and photograph if necessary any and/or all of the following:
 - a. Overall facility operations and conditions; and/or
3. To *monitor for, detect/prevent* FWA activities and/or transaction submission errors in the billing of Covered Prescription Services.

In-depth audits generally contain a larger number of transactions, include a comprehensive review of Prescriptions, as well as their supporting documentation, proofs of delivery, credentialing, licensure review, confirmation work and facility/ compliance reviews.

Audits may take the form of a phone call, on-site visit, or internal Claims review (desktop audit) and on-site facility reviews, client-directed or regulatory audits, investigational audits and or compliance reviews. The Network Pharmacy Provider will provide Administrator, Auditors, or its designee, during normal business hours, access to examine, audit, scan and copy any and all records deemed by Administrator or Auditor as necessary to determine compliance

with the terms of the Agreement and the PM. These audits are necessary for Clients or Benefit Plan Sponsors to comply with State and Federal requirements and Plan Specifications. Any discrepant Claims found during an audit will require reimbursement to Administrator. Audit recoveries will be deducted from future remittances to Network Pharmacy Provider. Should insufficient funds be available to offset such recoveries, Network Pharmacy Provider will be responsible to submit payment within fifteen (15) days of demand for payment.

Administrator routinely monitors online POS System Claims data and conducts audits on a continuous basis. In order to conduct these audits, Network Pharmacy Providers may be contacted by telephone, mail, fax, and/or email and are required to provide such records by the due date in a manner mutually agreeable by the parties, while at all times ensuring safe transmission of sensitive documentation.

Procedures for audit compliance

In general, the Administrator will notify the Network Pharmacy Provider no less than two (2) weeks advance written notification of a pending in-depth audit involving Claims review. However, if Administrator suspects that the Network Pharmacy Provider has engaged in fraudulent activity, Administrator or Auditor may conduct an on-site audit without advance notice. Should the Network Pharmacy Provider refuse to allow Administrator or Auditor access to the pharmacy facilities, Administrator reserves the right to recover the full amount paid or due to the Network Pharmacy Provider for any Claims subject to the audit and may terminate the Network Pharmacy Provider for cause.

As a Network Pharmacy Provider you are required to maintain Prescription records (including copies of Prescriptions and signature logs) in accordance with the Agreement, including the PM, and with applicable state and federal regulations. Administrator may request such records from the Network Pharmacy Provider pursuant to a Client, Benefit Plan Sponsor, Government Authority or regulatory audit or inquiry. Network Pharmacy Provider is required to assist Administrator with the retrieval of such records in a timely manner to allow Administrator to meet the deadlines as set forth by the Client, Benefit Plan Sponsor, Government Authority or regulatory agency.

On-site audits

- Network Pharmacy Provider will be contacted within seven (7) days prior to on-site audit with written or oral confirmation of date and an approximate time
- Network Pharmacy Provider must be adequately staffed to assist in the audit and answer any questions, retrieve information required and facilitate an effective on-site audit.
- Network Pharmacy Provider will provide Auditors a clutter-free work area, located away from the busiest areas of the dispensing department, with easy access to the required documents outlined in the audit notice
- Network Pharmacy Provider may not refuse a prescheduled on-site audit at the time of Auditor arrival. Auditor reserves the right to request copies or take digital images (i.e. scanned/photo) of aforementioned documents. A denial of this request will be determined to be denial of access.
- Auditor must be given a safe work space with a sufficient work surface that has adequate lighting and access to an electrical outlet within the confines of the Network Pharmacy Provider.
- Auditors will attempt to minimize any disruption of business processes while on-site.
- Auditors must be given full access to the books, records, files, lists, signature logs and documentation associated with any and all transactions related to Administrator Claims submitted by the Network Pharmacy Provider. Auditor reserves the right to request copies or take digital images (i.e. scanned/photo) of aforementioned documents. A denial of this request will be determined to be denial of access.

- Auditors must witness the physical extraction of original records from the Network Pharmacy Provider Archives (e.g., Network Pharmacy Provider records need to be pulled by Network Pharmacy Provider in view of the auditor). A denial of this request will be determined to be a denial of access.
- Auditor reserves the right to request copies/scanned images of original purchase invoices for Drug Products associated with the submitted Claims. Alternatively, a summary statement of purchases by NDC for the date range requested may be required to be requested of distributors by the Network Pharmacy Provider and be provided directly to Administrator by the distributor. Upon request, Auditor must be provided copies of drug pedigree documentation where applicable and copies of the front and back of all cancelled checks to support purchases. Also upon request, Auditor must be provided a comprehensive drug utilization report which includes all payers for NDCs requested (PHI redacted). A denial of this request will be determined to be denial of access.
- Auditor reserves the right for an extension of the original desk audit or on-site audit. A denial of this request will be determined to be denial of access.
- A denial of access is determined to be a breach of the audit provisions of the Agreement. The Network Pharmacy Provider may be subject to immediate suspension or termination for noncompliance.
- Access to Records and Audits. During the term of the Agreement and for a period of five (5) years thereafter, unless specifically restricted to a period of time less than five (5) years under state law Administrator or its designee shall have the right, upon reasonable notice and at reasonable times, to access, inspect, review, audit (including on-site and desktop audits) and make copies of the Records (“Administrator Audit”). In addition to the foregoing, Network Pharmacy Provider shall honor and accommodate all audit requests by Government Authority (“Governmental Audit”). Network Pharmacy Provider shall pay all costs incurred by Network Pharmacy Provider in connection with its provision of information for purposes of a Governmental Audit. The audit period shall, however, be ten (10) years in the case of Medicare Part D records.
- Network Pharmacy Provider must retain an Original Document of Record in its archives as required under State and Federal Law and for a period of no less than five (5) years from the date of the applicable transaction, and ten (10) years in the case of Medicare Part D records.
- Network Pharmacy Provider must provide a copy of any compound recipe worksheets identifying ingredients used in a Compounded Drug. Provider must submit all ingredients included in each compound and may only submit the NDC associated with the actual ingredients filled/dispensed.
- Each document as listed above is to be filed as an original document in the archives of the Network Pharmacy Provider, to be retrieved for inspection at the request for audit by Auditor.
- An original or digital image of the signature log will be accepted as audit evidence for receipt of goods.
- Network Pharmacy Provider will receive written disclosure of initial/preliminary audit findings subsequent to the field work for any in-depth audit.
- The Network Pharmacy Provider (or their pharmacy locations) will be given the opportunity to dispute any audit findings by filing an appeal within thirty (30) days, or as indicated by state law, from the receipt date of the initial/preliminary audit results letter. Such documentation must be sent via certified mail or other method that evidences tracking such as FedEx, etc., to the attention of the Administrator Network Audit Manager, or as otherwise instructed in the initial/ preliminary audit results letter. Upon extenuating circumstances, a request for an extension may be granted at the sole discretion of Administrator. Receipt of such an extension request must be received in writing within the required thirty (30) days appeal time frame or as otherwise instructed in the initial/preliminary audit results letter. Failure to submit appeals by the time frame allowed will subject any applicable discrepancy to recoupment as indicated in the initial/preliminary audit results letter.

- Post-audit documentation must consist of original hard copies of Prescriptions (no verbal orders) or other original documentation as approved by Administrator.
- Final audit findings will be provided after the dispute period has lapsed, in accordance with any applicable state law, and with consideration of any dispute that was filed timely. Audit findings will indicate where a full or partial recoupment is necessary, or indicate that a finding is educational only. The Network Pharmacy Provider will receive a chargeback against future remittances until paid-in-full for any discrepancies found during the audit. Payments to Administrator are only necessary if the Network Pharmacy Provider is no longer operating, if there is no current Agreement in effect, or if insufficient payment activity is available to offset the chargebacks within a reasonable time period.
- Administrator at its sole discretion may elect to notify a PSAO of any significant audit findings, if the pharmacy in question is affiliated with a PSAO.
- Administrator shall have the right, with or without notice, at reasonable times, to perform a facility review to inspect the Pharmacy location for compliance. Request for copies or digital images (i.e. scanned/photo) of documents pertaining to the review may be requested. Pharmacy agrees to cooperate with Administrator during the on-site pharmacy facility review and acknowledges non-cooperation with such on-site pharmacy facility review may result in denial or termination of network participation.
- Facility reviews may include review, as well as documentation of all applicable licensures, proof of identification of employees, compliance with all federal/state regulatory requirements, proof of compliance with return to stock policy, which must be fourteen (14) days or fewer from the date Claims are submitted to Administrator, various other reviews and inquiries to assure that overall quality assurance measures are implemented.
- Facility reviews may require proof of compliance in providing the Medicare Prescription Drug Coverage and Your Rights notice to all Medicare Members when a Prescription cannot be covered ("filled") under Medicare Part D ("Part D") benefit in the POS System and the coverage determination results in a 569 reject response.
- Purchases for any Claims submitted to Administrator must be made from a licensed wholesaler as regulated by state and federal entities. This requirement includes the purchase of non-legend items (e.g. OTC, supplies). Network Pharmacy Provider must be able to document the source is authorized to include federal/state licensure, oversight by regulatory agencies to include the Food and Drug Administration (FDA), Drug Enforcement Administration (DEA) and ability to obtain pedigree information for Drug Products. Network Pharmacy Provider must promptly comply with any requests to produce such documentation. Any inter-pharmacy transfers must be accurately and completely documented in a manner consistent with federal/state laws, as well as industry standards.

Documentation and submission expectations

- Network Pharmacy Provider shall maintain adequate Prescription, as well as financial records relating to the provision of Covered Prescription Services to our Members, including but not limited to: Network Pharmacy Provider books/databases, daily Prescription logs, patient profiles, Prescription hardcopies, Prescriber information, signature/delivery logs, refill information, wholesaler/manufacturer/distributor/all other purchase invoices, business records such as FWA training logs LEIE/EPLS verifications, availability of notices such as the CMS10147 and other federal/state required documents, policies, including other such documentation necessary for all Covered Prescription Services provided. Network Pharmacy Provider shall also maintain all policies and procedures related to maintenance of such records. Network Pharmacy Provider shall maintain/retain all records described herein for a no less than five (5) years from the date of the applicable transaction or as required by law and ten (10) years in the case of Medicare Part D records.

The information provided below is intended to clarify documentation expectations related to particular items to help Network Pharmacy Providers avoid problems and be prepared for an audit.

Prescription records

All Prescription documentation, regardless of the way it has been created, generated, or transmitted shall contain the following:

- Full name of the Member for whom the Prescription was written, and the address of the Member along with a date of birth,
- Full name and address, telephone number and any other required identifiers of the Prescriber,
- Name, strength, and quantity of the medication prescribed,
- Specific dosing directions, if a Prescription contains ambiguous directions the Provider must clarify these directions and note the conversation to clarify,
- Substitution instructions where applicable, or substitution requested by Member clearly noted,
- Refill instructions,
- Miscellaneous or other informational notes as required by applicable laws or regulations, and
- Complete documentation of items, quantities to be dispensed, and directions for use for diabetic supplies and insulin.

Prescription records must be updated yearly, or such shorter period required by applicable law. If applicable law does not specify a time period, Administrator requires that Prescription hard copies be updated yearly.

Administrator recommends that Network Pharmacy Provider document as much information as possible on the Prescription itself, outlining any unusual circumstances that occurred while dispensing the Covered Prescription Service. Such notes may eliminate a question from the Auditor or help resolve a discrepancy.

The hard copy (original and any updates) of the Prescription, including telephone Prescriptions, must contain all data elements required by state pharmacy laws in which Network Pharmacy Provider is located and all Prescriber instructions — including Product Selection Code instructions — that support the Network Pharmacy Provider's Claim transmission.

Prescriptions in which the dosage/quantity is changed require either written documentation on the Prescription or a new hard copy Prescription to be issued. When the Prescriber writes as directed, a documentation as to the exact directions or, at a minimum, the maximum (up to) dose of medication taken per day must be documented on the hard copy or electronically and be viewable upon request. Only Prescriptions generated by the Prescriber are accepted as post audit documentation for as directed Prescriptions.

If less or more medication (if permitted) is given than ordered by the Prescriber, the reason for this must be documented. Any increase in the amount of Drug Product over the original prescribing order must be documented for Prescriber authorization.

Wholesaler, manufacturer, and distributor invoices

Wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents must be accessible, maintained for a minimum of five (5) years or as required by law or regulation and ten (10) years in the case of Medicare Part D records to substantiate that the Drug Products dispensed were purchased from an authorized source regulated by the federal/state entities, to include valid licensure in the state the Drug Product is dispensed. Purchases for any Clean Claims submitted to Administrator must be made from a licensed wholesaler as regulated by federal/state entities. This requirement includes the purchase of non-legend items (e.g. over-the-counter supplies). Network Pharmacy Provider must be able to document that the source is authorized to include state or federal licensure, oversight by regulatory agencies to include the Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA), and ability to obtain pedigree information for Drug Products. Network Pharmacy Provider must

promptly comply with any requests to produce such documentation. If Network Pharmacy Provider fails to promptly provide such requested documents, Network Pharmacy Provider may immediately offset 100% of the amount for any of the paid claims in question and impose additional fines or penalties. Network Pharmacy Provider shall remain responsible for the validation a wholesaler, from which they are provided Drug Products, has valid pedigree. Network Pharmacy Provider shall maintain adequate records to further validate purchases from wholesalers to include canceled check information available for audit.

Network Pharmacy Provider may not enter into a captive pharmacy arrangement, whereby the pharmacy enters into agreement for the marketing and dispensing of Drug Products specifically for a manufacturer without disclosure to Administrator, as well as written permission by Administrator.

Signature log — hard copy or electronic

Network Pharmacy Provider shall require the signature of the Member or the Member's representative on a permanent record before dispensing any Prescription. All logs must be maintained for all Claims submitted on-line via the POS System to Administrator.

At each Network Pharmacy Provider location, Network Pharmacy Provider shall maintain a hard copy or, if pre-approved by Administrator, an electronic or manual signature log which contains the following: the Prescription number; the date the Drug Product is received by the Member; and the signature of each Member who receives a Drug Product or the signature of his/her designee, and the authorization to release information to a third party program.

Network Pharmacy Provider must obtain a legible written signature or electronic capture that corresponds to a matched printed name or another authorized person to confirm receipt of the Prescription product. Capture of non-signature data elements to document receipt of the Covered Prescription Service (e.g. electronic delivery notice or point-of-sale information) must be only upon express permission of Administrator. Proper verification of the person picking up the Covered Prescription Service is essential to ensure the deterrence of potential fraud and abuse.

- If delivered to a home or business address, Network Pharmacy Provider must obtain the signature of the Member or his/her designee at the time of delivery.
- If patient is sent monthly billing statements, Network Pharmacy Provider may insert a form listing the dates of fill and Prescription numbers; the eligible Member or authorized representative should be instructed to sign and return the form with his/her payment.
- Provider using mail services must include information to document tracking of shipment, confirmation of delivery, or other proof of delivery.

These Prescription signature logs must be in date order where appropriate and readily accessible.

Insulin and diabetic supplies

Provider may only submit the NDC associated with the actual insulin or diabetic supply filled and dispensed. Diabetic insulin and supply must be calculated to accurately submit the days' supply. Directions notated as needed or as directed require a documented interaction with the Prescriber or Member on the Prescription.

If Prescriber indicates as directed or as directed as per sliding scale, Network Pharmacy Provider must obtain the dosage range, note it on the Prescription hard copy, and calculate the days' supply by using the maximum (up to) daily dosage. The directions may be obtained by direct communications with either the Member or Prescriber.

Inhalers and inhalation products

When submitting a Claim, enter the quantity to be dispensed exactly as written by the Prescriber on the Prescription form. Dispensing limitations vary widely among Benefit Plans. Depending on the Member’s medical condition, it may be necessary to dispense more than one inhaler. If Benefit Plan design allows and the Prescriber writes accordingly, the Member may obtain more than one inhaler per Prescription.

Ophthalmic products

Eye drops should be calculated using 15 drops per mL, unless a more specific drop per mL or uses/package exists. Prescriptions with defined length of therapy may use that period for days’ supply when smallest package size available in the market for therapy is used (e.g. 5ml ophthalmic with acute therapy of 5 days).

15 GTTS/	2.5ml	5ml	10ml	20ml
One	37	75	150	225
Two	18	37	75	112
Three	12	25	50	75
Four	9	18	37	56

* If the minimum quantity as represented by the manufacturer’s smallest available unit-of-use causes a rejection, with notation of a maximum days’ supply, it is allowable to resubmit with the communicated days’ supply which represents the plan maximum.

Desktop and telephone audits

Administrator conducts desktop audits and investigational audits to verify the accuracy and validity of Claim submissions. Network Pharmacy Providers are typically contacted via telephone, fax, or mail and asked to provide photocopies of specific documents and records related to Claims paid to Network Pharmacy Provider by Administrator during a specified period. Requested documentation may include, but is not limited to, original Prescriptions, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications. Administrator will identify any discrepancies found in the documentation and will advise Provider of such via post audit reports. Provider is required to correct the claims through resubmission if requested by Auditor.

Administrator monitors claims data for potential billing errors and reasonable claim submissions on a daily basis. If a potential discrepancy is found, an Auditor will contact the Network Pharmacy Provider, typically via telephone, to inquire about, validate, and help resolve any discrepancy. Unless supporting documentation is required, most of these discrepancies can be validated with minimal correspondence and resolved through Claim reversal and resubmission by Network Pharmacy Provider.

- Network Pharmacy Provider is required to answer reasonable telephone inquiries by an Auditor or a designee, as determined solely by Administrator, to validate a Member being billed, Prescription directions, Compounded Drug ingredients, quantities being dispensed, etc.
- All in-depth desktop audits will be directed by written correspondence.
- Where billing agents are utilized by a Network Pharmacy Provider, Administrator may coordinate audits with the billing agent, but Network Pharmacy Provider remains responsible for all billing outcomes, verification and validation.
- Network audits may be performed by Administrator staff, or by an agent authorized solely by Administrator.
- In cases where the desktop audit is related to a Member complaint, Network Pharmacy Provider shall respond to desktop audit requests within three (3) business days.

Investigative reviews

Administrator conducts investigational reviews to verify the accuracy and validity of Claim submissions and verification of Drug Product and supply purchases. Requested documentation may include, but is not limited to, original Prescriptions, signature logs, computer records, and wholesaler invoices showing purchase or receipt of dispensed Covered Prescription Services. Network Pharmacy Provider will receive thirty (30) calendar days, unless another time is dictated by federal/state guidelines or law, to provide the necessary documentation needed to satisfy the review. Administrator will identify any discrepancies found in the documentation and will advise Network Pharmacy Provider of such via a post-review report. Network Pharmacy Provider will receive a ten (10) business day appeal time frame to submit any additional documentation needed to refute the findings.

Please Note:

All invoice purchase history must come directly from the wholesaler, purchase history received from the Network Pharmacy Provider will not be accepted.

Post-audit reporting

Network Pharmacy Provider may receive a post-audit report if specific Claims require additional documentation. Additional documentation is typically required within a thirty (30) calendar-day period to contest any findings identified, unless another time is dictated by federal/state guidelines or Law. At the completion of the audit, Network Pharmacy Provider may also receive a final audit report with the Claims identified as discrepant and due for recovery. All documentation must be received no later than thirty (30) calendar days from the date of the discrepancy report. Beyond that date, the audit will be considered final

Miscellaneous audit information

In situations where cumulative errors rise to the level of negligence, FWA, as determined solely by Administrator, Administrator reserves the right to extrapolate audit sample exceptions against the entire population under audit, subject to applicable law or Government Authority.

The following is a partial list of audit violations which could be perpetrated by a Network Pharmacy Provider resulting in Claims being recovered in total and no reimbursement will be forthcoming for what was actually dispensed. In addition, legal or other action may be taken against the Network Pharmacy Provider, including immediate termination of the Agreement:

- Billing for a Brand Name Drugs and dispensing Generic Drugs
- Billing of an NDC for other than what was dispensed
- Overbilling of quantity prescribed
- Inappropriate billing of Compound Drugs
- Claims for Covered Prescription Services that include as a component of the Compound Drug a National Drug Code (“NDC”) for a repackaged drug; or
- Drugs imported or reimported into the United States, including bulk powders utilized in Compound Drugs where part of the final Compound Drug dispensed is composed of an imported component are subject to full recovery
- Undocumented substitution
- Non-covered item billed as covered
- Duplicate Claim billed
- Billing for more Drug Products than dispensed (pill shorting)
- Submitting Claims for Drug Products not rendered and/or prescribed

- Submission of dummy DEA/NPI or Invalid DEA/NPI numbers to obtain a paid response
- Billing for Brand Name Drug with DAW 1 when a Prescriber has not specified “Do Not Substitute” on the Prescription, or other inappropriate use of DAW codes
- Billing Claims for more fills or refills than were authorized or illegal refill of a schedule II narcotic Prescription
- Covered Prescription Services filled after their legal time limit
- Billing for invalid Prescriptions due to lack of a legal Prescriber, forgery, or false or fictitious documents
- Covered Prescription Services filled incorrectly based on original order
- Refills too soon that were paid due to a prior days’ supply violation
- Inability to locate the original Prescription (missing)
- Covered Prescription Services lacking sufficient proof of delivery to Member
- Covered Prescription Services where a Member denies receiving Drug Products billed
- Covered Prescription Services where Prescriber denies prescribing Drug Products billed
- Covered Prescription Services returned to stock but not reversed
- Prescriptions missing date written, or filled before date authorized
- Prescriptions missing Prescriber signature
- Prescription missing any other required information by federal/state government or is otherwise not a legal Prescription
- LTC Network Pharmacy Provider billing for unused Drug Products and not applying credit to Member
- Drug Product to be billed under Medicare Part A or Part B versus under Part D
- Inappropriate, inaccurate or incomplete record-keeping practices related to billed Prescriptions
- As-Directed/UD SIGS: Network Pharmacy Provider must submit an accurate day’s supply based on Prescriber’s directions for use. In cases where directions are not specific, such as “Use as Directed”, “UD”, etc., Network Pharmacy Provider must obtain clarification from the Prescriber or patient as to the specific directions on which to base the correct days’ supply submitted for the quantity billed. Specific directions must be noted on the Prescription hard copy or in Network Pharmacy Provider’s electronic records system
- Use of coupons when prohibited by Benefit Plan including, but is not necessarily limited to, programs funded by the federal government (e.g. Medicare, Retiree Drug Subsidy (RDS) plans and Medicare Part D)

The following is a partial list of audit violations which could be perpetrated by a Network Pharmacy Provider where Claims will be recovered for a partial reclaim of the Covered Prescription Services or recovered in total if a pattern of Abuse is evident. In addition, legal or other action may be taken against the Network Pharmacy Provider, including termination of the Agreement:

- Overbilling of quantity in relation to days’ supply that exceeds plan maximums, or not in conformance with that prescribed.
- Billing for larger pack sizes when one smaller pack size will meet the directions of the Prescriber and remain within the Benefit Plan’s maximum days’ supply
- Prescription splitting to obtain multiple dispensing fees or undermine prior authorization or quantity limits, etc.
- Billing multiple lower strengths when one higher strength Drug Product prescribed.

Again, the above is only a partial listing of sample audit violations. A more complete list with expanded descriptions can be found in the Appendix.

Administrator reserves the right to assess a penalty equal to the entire amount of the Claim (including copayment) for each violation, in addition to the Covered Prescription Services value or difference in billing being recovered.

Material repetition or pattern of practice of any given category of audit violation or the material combination of different categories of violations discovered during an audit may subject Network Pharmacy Provider to further disciplinary action potentially including termination from Administrator Network(s).

Instances of alleged FWA discovered during audit shall subject Network Pharmacy Provider to immediate termination.

Any Network Pharmacy Provider terminated from Administrator network(s) for reason(s) other than suspected fraud and Abuse must wait a minimum of five (5) years from date of effective termination before applying for reconsideration regarding Agreement participation. Network Pharmacy Provider terminations for suspected Fraud and Abuse are considered permanent.

Withheld amounts due to audit findings that are not documented within three (3) months are subject to refunding to Clients without further appeal.

Subject to applicable Law, Administrator at its sole discretion may suspend Claims payments to Network Pharmacy Provider for an indefinite period of time on behalf of any or all Benefit Plan Sponsors, including but not limited to when at the request of any Government Authority, direction by subpoena, non-response to an audit request, pending the outcome of an Audit and/or reasonable belief Network Pharmacy Provider is engaged in fraudulent or illegal activity.

Prescription origin code claim submission

Administrator routinely performs audits of Claims for Covered Prescription Services submitted by Network Pharmacy Providers. Discrepancies found during an audit may be subject to recoupments depending on the nature of the findings. This information is intended to educate Administrator Network Pharmacy Providers on how to correctly submit Prescription Origin Code in conformance with the NCPDP and Administrator requirements.

Please submit one of the following data elements within Prescription Origin Code (419-DJ):

- 1 = Written
- 2 = Telephone
- 3 = Electronic
- 4 = Facsimile (Fax)

Claims submitted for a Prescription missing one (1) of these values will reject with the following NCPDP Rejection Code 33 — “RX ORIGIN CODE CANNOT BE “0” ON NEW CLM”.

If rejection occurs, please resubmit the Claim with the appropriate value.

Audit dispute resolution procedure and audit collections/final audit remedies

Administrator maintains an ongoing Pharmacy Audit Program to ensure Network Pharmacy Providers are in compliance of their Agreement. Notwithstanding rights included in the Agreement or the PM, dispute resolution, Administrator has established the Pharmacy Audit Review Committee (PARC); an internal hearing process that is independent of the particular individual Auditor who conducted the audit, allowing an audited Network Pharmacy Provider to submit a request for reconsideration of an unfavorable audit determination. Please refer to the audit communications as provided by Auditors for discrepancies identified and the actions a Network Pharmacy Provider may take to remedy such discrepancies. Please be aware the PARC process is not a vehicle for submission of new materials for inclusion in the audit review, but is designed to provide a re-determination of previously submitted post-audit documentation. The PARC process is not available to pharmacies terminated or disciplined for reasons associated with suspected fraud or abuse.

Requests for reconsideration are submitted to, and reviewed by, the PARC, which is comprised of pharmacists and other professionals from within Administrator, but otherwise not associated with the Administrator’s Auditor or Network Audit Department.

In cases where pharmacies disagree with the Administrator's decisions or policies relating to final audit findings they are given a one-time opportunity to respond to final audit findings by filing a written request for reconsideration within thirty (30) days from the date of the final audit report. Documentation related to the request for reconsideration must be received by Administrator within thirty (30) days of the Final Findings Letter.

Administrator may begin offset of audit finding amounts against any future payments due to Network Pharmacy Provider and impose certain fines or penalties prior to the outcome of the PARC process. Administrator has the right to assess reasonable fines, penalties and fees to cover unexpected costs. These actions may include the imposition of fines or penalties due to repeated audits, probation, termination from the network and corrective action plans.

If a Network Pharmacy Provider is not in agreement with Administrator's final findings and would like to file a request for review by the PARC, please contact Administrator at **PARC@optum.com** to request a copy of the PARC Audit Review Request Form, as well as instructions.

Long term care (LTC) providers

Administrator reserves the right to audit a LTC Network Pharmacy Provider's books, records, Prescription files, and signature logs for the purpose of verifying Claims submission information. LTC Network Pharmacy Providers are required to have a signed Prescriber's order available for audit. These orders may be in the form of a standard Prescription or copies of signed Prescriber's orders from a medical chart. Record retention is important, and time to retrieve these documents is considered in complying with audit requirements. LTC Network Pharmacy Providers are not required to have a signature from the member as proof of receipt. However, LTC Network Pharmacy Providers must have delivery logs, manifests or other Administrator approved proof of delivery of Covered Prescription Services to facilities readily available during an audit.

Abuse of the Short Cycle Dispensing regulations as defined by CMS and implemented on 1/1/2013, will be subject to audit and recovery of overpayments resulting from abuse and any attempt to achieve multiple dispensing fees based on days' supply manipulation. Administrator may also audit to find attempts to gain more than two (2) dispensing fees in a one (1) month period.

LTC Network Providers must dispense drugs and report information as required by 42 CFR §423.154. Administrator shall reimburse LTC Network Pharmacy Providers in accordance with 42 CFR §423.154.

C. Data accuracy

Entry of the Prescriber and Member information is paramount in being able to identify true occurrences of fraudulent and abusive practices, as well as reduction in waste associated with payment of Claims for excluded Prescribers. For additional information regarding data accuracy, see Processing Claims section. Network Pharmacy Provider agrees to follow all federal and state requirements, including Medicare and Medicaid rules, accurate submissions and temporary supply rules which are mandated by many of these programs. In addition, Network Pharmacy Provider will facilitate when professionally capable or provide a valid reason for their inability to participate in a state Medicaid Benefit Plan's Lock-In program for its membership.

D. OIG/GSA validations

Network Pharmacy Provider must have a policy and procedure for checking the Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) or General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS) to confirm Network Pharmacy Provider does not employ or contract with any individual or entity which is excluded from participation in federal programs. LEIE and EPLS verifications must be conducted at least monthly and upon initial hire or contracting. If Network Pharmacy Provider discovers an individual or entity responsible for the provision of pharmacy services is on the LEIE or EPLS as excluded, Network Pharmacy Provider must report this issue and all the Claims associated with the excluded individual or entity to Administrator Provider Relations at:

provider.relations@optum.com.

In addition, Network Pharmacy Provider hereby verifies and certifies the Network Pharmacy Provider has not been excluded from participation in federal health care programs by checking its status in Federal programs exclusion lists maintained by the Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) or General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS).

This information is available at the following sites:

- Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) — <http://oig.hhs.gov/exclusions/index.asp>
- General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS) — <https://sam.gov/portal/SAM/#1>

You are required to report any suspected or potential FWA.



To report an incident, please contact the Pharmacy Network Relations Department at **1-800-613-3591** or via email to **pharmacyprograms@optum.com.**

Client(s) or Benefit Plan Sponsors, FDR entities (including Network Pharmacy Providers) should initiate an inquiry immediately, but no less than two (2) weeks from the date a potential fraud matter is identified. If, upon investigation, the Network Pharmacy Provider believes potential misconduct has occurred, the Network Pharmacy Provider may also report the alleged activity to any of the following:

- Customer service number identified on the back of a Member's ID card
- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
— 1-877-7SAFERX (**1-877-772-3379**)

VIII. Pharmacy network participation requirements



A. Network Pharmacy Provider Participation

Administrator appreciates your participation in its pharmacy network and your role in delivering quality pharmacy Covered Prescription Services to our Members. As a Network Pharmacy Provider, you are responsible for monitoring and complying with all changes to the PM. Failure to adhere to any of the provisions, as well as the terms of the Agreement, which includes this PM and all other applicable documents, will be viewed as a breach of the Agreement.

Network Pharmacy Provider agrees to abide by the terms of the PM, comply, participate with Administrator and/or its Client's to research, as well as resolve network related issues (i.e. Claim reversal/resubmission requests, Member's complaints, grievances and/or appeals).

In the event of any request pertaining to network participation, service inquiries or any additional concerns which may relate to Covered Prescription Services for our Members, Network Pharmacy Provider must respond to expedited requests within three (3) business days and routine requests within ten (10) business days of receipt or as required by law/regulation. An expedited request is defined as any inquiry impacting the Member's ability to obtain their Covered Prescription Services and/or inquires involved in assessing quality of care, investigating a Members' grievances or complaints.

Please Note:

Network Pharmacy Provider's participation in an Administrator or Client network shall not guarantee participation in all networks. Administrator reserves the right to limit Network Pharmacy Provider's (and any of its pharmacies') participation in a network in its sole discretion.

Network Pharmacy Provider understands Administrator is relying on its participation in applicable networks and as such shall not be allowed to opt-out of any networks without the written consent of Administrator.

A Network Pharmacy Provider shall be required to adhere to all requirements set forth in Risk Evaluation and Mitigation Strategies (REMS) programs defined by the Food and Drug Administration (FDA). Network Pharmacy Provider shall maintain appropriate documentation as to provide evidence the requirements of a REMS program were satisfied during the dispensing of any Drug Products associated with program.

B. Prohibited activities by Network Pharmacy Provider and associated penalties

Network Pharmacy Provider is subject to penalties or sanctions in the event it is determined by Administrator during communications between Network Pharmacy Provider and an existing Client or a potential Client: (i) Network Pharmacy Provider disclosed confidential information to a Client or a potential Client or (ii) disrupted an Administrator relationship with its existing Client or with a potential client. Penalties shall be invoked in amounts at a minimum of \$5,000 per incident/per day, may be subject to additional actions taken by Administrator, including, as well as up to termination from participation, withdrawal and/or the holding of funds as deemed necessary by Administrator.

Non-solicitation

Any violation of this non-solicitation section shall be deemed a material breach and Administrator shall have the right to terminate the Agreement with respect to Network Pharmacy Provider or any of its individual locations or impose penalties as Administrator deems appropriate to address such violations, in addition to any other rights Administrator has in the Agreement, at law or in equity.

Network Pharmacy Provider will refrain from advising or soliciting any Members with plans utilizing Administrator for any reason, including, but not limited to improving compensation.

Network Pharmacy Provider will refrain from advising, counseling or soliciting any plans to terminate its relationship with Administrator for any reason, including, but not limited to improving compensation level or the termination of this Agreement.

Network Pharmacy Provider may not obtain its patients via cold-calling or unsolicited methods of obtaining a Member's billing information or to make offers of contacting the Member's Prescriber. All submission of Claims for a fill or refill of a Drug Product by Network Pharmacy Provider must be initiated in accordance with a Member's knowledge and authorization.

Network Pharmacy Provider shall not solicit, as a matter of routine business practice, a Member for mail delivery or deliver any Covered Prescription Services to a Member by mail (e.g. UPS, USPS, Fed-Ex) except upon the advance written approval of Administrator, which approval may be refused in Administrator's sole discretion.

Noncompliance

Network Pharmacy Provider must provide Covered Prescription Services related to a covered item to all Members of all Benefit Plan Sponsors in compliance with the PM and as set forth within the Agreement. Noncompliance may include, but is not limited to, the disclosure of confidential information or data, submitting incorrect DAW code, submitting an inaccurate U&C price, submitting incorrect Claim submission data, the collection of a patient pay amount that differs from the amount specified in the Claims response, failure to dispense an emergency supply of a covered item to a Member as required by law, failure to dispense covered Drug Product based on reimbursement received and the refusal to accept an identification card for a Member.

Should the Network Pharmacy Provider be deemed noncompliant, certain remediation actions may apply, including, but not limited to a corrective action, probation, termination of the Agreement and any other available recourse.

Should the Network Pharmacy Provider's actions or inactions result in any fees, interest penalties, damages, withholds, judgments, financial obligations or other charges imposed upon Administrator, such shall be paid in full by Network Pharmacy Provider within the time period specified by Administrator.

For each submitted Claim deemed noncompliant, Administrator in its sole discretion may assess against Network Pharmacy Provider up to a \$100 administration fee per occurrence. Administrator reserves the right to offset against any amounts owed to Network Pharmacy Provider and any such amounts owing to Administrator for discrepant Claims or other charges for noncompliance or audit-related costs.

Termination and appeal process

Except for non-renewal of the Agreement at the end of a term thereof, Network Pharmacy Providers terminated in accordance with the Agreement or PM will be provided a written notice describing the reason(s) for such termination and an opportunity to request a hearing to appeal such termination.

Network Pharmacy Providers terminated from participation may apply for reinstatement after five (5) years from the date of such termination. Such reinstatement is at Administrator's sole discretion.

Termination of Network Pharmacy Providers participation in the Agreement for any reason pursuant shall not affect the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination.

After the effective date of Network Pharmacy Providers termination of participation in the Agreement in its entirety, Network Pharmacy Provider shall make an accounting of all monies due hereunder to Administrator or any Client and shall pay such amount due to Administrator, including payment for any non-Clean Claims or outstanding balances from reversed, but not reprocessed Claims.

Network Pharmacy Provider acknowledges the right of Administrator or Administrator's Clients to inform Client's Members of Network Pharmacy Provider's termination, suspension, limitation, exclusion or revocation and agrees to cooperate with Administrator and/or Administrator's Clients with transferring any Prescriptions to a Network Pharmacy Provider.

C. Credentialing and quality management

All Network Pharmacy Providers must comply with credentialing and quality management initiatives required by Administrator. Network Pharmacy Provider agrees to provide Administrator with documentation and other information which may be needed in connection with such initiatives.

Administrator has the right to reasonably determine, in its sole discretion, whether or not Network Pharmacy Provider meets/maintains the appropriate credentialing, as well as quality management standards to serve as a Network Pharmacy Provider for Administrator, its Clients and Benefit Plan Sponsors.

Administrator may request copies of all documents required for the credentialing of a Network Pharmacy Provider at any time. Appropriate documents must be provided within forty-eight (48) hours of request.

- Network Pharmacy Provider and each pharmacy location covered under the Agreement, as well as this PM must meet all standards of operation as described in federal/state law.
- Network Pharmacy Provider must at all times maintain in good standing with all federal, state, as well as local licenses and/or permits as required by applicable law. Network Pharmacy Provider must furnish copies of said licenses and/or permits upon initial enrollment as a Network Pharmacy Provider with Administrator and subsequent requests by Administrator. Network Pharmacy Provider may be required to maintain an unrestricted Drug Enforcement Agency (DEA) registration for all controlled substances as determined by Administrator. Failure to maintain the appropriate licenses and/or permits will result in immediate termination as a Network Pharmacy Provider.
- Network Pharmacy Provider must notify Administrator in writing if:
 1. Network Pharmacy Provider's license/permit is in jeopardy of being suspended or revoked.
 2. Network Pharmacy Provider receives notice of any proceedings which may lead to disciplinary action.
 3. Any disciplinary action is taken against Network Pharmacy Provider or any of its personnel, including but not limited to, action taken by a Board of Pharmacy, OIG, GSA, law enforcement or other regulatory body;
 4. There is a subpoena of records related to Covered Prescription Services or Network Pharmacy Provider's business conduct; or
 5. There is a seizure by law enforcement of Network Pharmacy Provider's Prescription records, computer systems, financial records, accounts or real property.

Please Note:

Network Pharmacy Provider must provide notice to Administrator within seven (7) days of the occurrence or earlier per the Agreement and include information regarding the agency conducting the investigation, if applicable. Failure to timely and properly notify Administrator may result in immediate termination of the Agreement or suspension as a participating Network Pharmacy Provider pharmacy location. Administrator may, in its sole discretion immediately

suspend, pending further investigation, the participation status (which may include temporary payment withholding or Claims adjudication suspension) of Network Pharmacy Provider if Administrator has reason to believe Network Pharmacy Provider has engaged in or is engaging in, any behavior which (1) appears to pose a significant risk to the health, welfare, or safety of Members or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; or (3) otherwise reflects negatively upon the Network Pharmacy Provider's ability to fulfill the requirements of the Agreement.

Independent pharmacy credentialing

In order to become an independent Network Pharmacy Provider, Pharmacy must submit a credentialing application, complete a Disclosure of Ownership and Control Interest Statement form, complete a Credentialing and Re-Credentialing Application Fee form, meet the Administrator credentialing requirements and be able to comply with the requirements of the Agreement and PM. All Network Pharmacy Providers shall be credentialed pursuant to the Administrator credentialing policy prior to submitting any Claims for Covered Prescription Services.

Network Pharmacy Provider shall be responsible for paying the Credentialing and Re-Credentialing Fee upon initial application to contract with Administrator and upon full re-credentialing, when applicable. Each of the Credentialing/Re-Credentialing Fees are subject to change by Administrator. Network Pharmacy Provider agrees any applicable Credentialing/Re-Credentialing Fee may be deducted and recouped from any Prescription Drug Compensation due to Network Pharmacy Provider hereunder.

To reach the Credentialing department, please contact the Administrator at:

Pharmacy Network Credentialing Department
17900 Von Karman
(MS: CA016-0200)
Irvine, CA 92614
Telephone: **1-800-613-3591**
Fax: 1-866-811-4224
Email address: **pharmacycredentialing@optum.com**

Mail order pharmacy additional credentialing requirements

Any pharmacy requesting mail order pharmacy network access must be certified with Verified Internet Pharmacy Practice Sites (VIPPS) and accredited by URAC, formerly known as Utilization Review Accreditation Commission, for the applicable accreditation.

Additional information regarding these organizations and criteria for certification may be found at the following websites:

VIPPS: <http://vipps.nabp.net/>
URAC: <https://urac.org/>

Specialty credentialing

Some Client's and Benefit Plan Sponsors may adopt a Specialty Credentialing Program for Network Pharmacy Providers participating in a Retail Pharmacy network. Network Pharmacy Provider must supply acceptable reference documentation to meet Administrator's Specialty Pharmacy Network requirements. If Network Pharmacy Provider

wishes to participate in the routine dispensing of Specialty Drug Products, Network Pharmacy Provider should request credentialing materials from Administrator. Administrator may prohibit Network Pharmacy Providers who have not satisfied all of the requirements of the Specialty Credentialing process and have not executed a separate Specialty Addendum from submitting claims for Specialty Drug Products. Obtaining Specialty Credentialing may not grant access by Network Pharmacy Provider to dispense Specialty Drug Products for all Clients or Benefit Plan Sponsors.

 To obtain information on Specialty Credentialing, please reach out to: specialty.credentialing@optum.com.

Compound credentialing

Administrator may require pharmacies to meet additional credentialing requirements to be allowed to process Compounded Drug Claims. Administrator may delegate responsibility to a third-party vendor, such as United Compounding Management LLC, to assist in the credentialing process of Network Pharmacy Providers to process Compounded Drug Claims. Network Pharmacy Providers will be required to meet all of the credentialing standards established by Administrator and/or the third party vendor to include, but not limited to: PCAB accreditation, continuous quality improvement process inclusive of validation testing for stability/sterility, an ethics management compliance review to include business operations, compliance with Anti-Kickback, as well as Stark law, federal/statel pharmacy law, defined allowable sales/marketing conduct, a defined compounding code of conduct, including provider manual and an on-site credentialing review. Network Pharmacy Providers must maintain compliance with all credentialing requirements and standards of practice set forth by Administrator or the third party vendor. Failure to maintain compliance with the requirements and standards may result in administrative action up to and including the termination of the Agreement. All Network Pharmacy Providers, including those credentialed, must meet abide by Section Compounding pharmacy participation in retail networks.

 To obtain information on Compound Credentialing, please reach out to: credentialing.contracting@optum.com.

PSAO credentialing requirements

If you are a PSAO or a pharmacy contracted with a PSAO for participation in Administrator's networks: A PSAO must certify pharmacies are affiliated with the PSAO meet the Administrator requirements, including the presence of an ongoing policy to ensure the pharmacies meet these requirements and abide by the Agreement, as well as the PM.

 Failure to meet these duties and obligations may result in termination of such PSAO Agreement or a Network Pharmacy Provider.

- PSAO maintains a credentialing program for itself and each of the member pharmacies.
- PSAO and Network Pharmacy Provider agree Administrator, as well as Administrator's Clients have the right to monitor and oversee PSAO's credentialing program.
- Accordingly, upon reasonable advance notice, PSAO and Network Pharmacy Provider will provide Administrator, as well as Administrator's Clients with on-site access to all records maintained by PSAO relating to the credentialing of each Network Pharmacy Provider, including all Pharmacists which provide Covered Prescription Services to Members or, at Administrator's election, PSAO shall provide Administrator with copies of such records (e.g. then-current credentialing policies and procedures) and/or certifications of PSAO's compliance with these requirements.
- PSAO and Pharmacy acknowledges Administrator or Administrator's Clients may independently verify licenses, insurance coverage, any debarment or disciplinary action related to all Network Pharmacy Providers and Pharmacists who provide Covered Prescription Services to Members.

- Upon request, PSAO shall submit credentialing information specified in the credentialing requirements document or the Agreement, to Administrator within five (5) days following the execution of the Agreement so Administrator, as well as Administrator's Clients may determine whether Administrator and Network Pharmacy Provider have met Administrator's credentialing requirements.
- PSAO shall maintain a compliance monitoring program pursuant to which the PSAO, on no less frequently than an annual basis, verifies the Network Pharmacy Provider DEA licenses, insurance coverage, government program exclusions, debarment, including any disciplinary action related to all Network Pharmacy Providers, pharmacy owners, as well as personnel utilized by PSAO and Network Pharmacy Provider to provide Covered Prescription Services to Members. PSAO agrees to provide updated information relating to such matters to Administrator upon change.
- PSAO shall ensure to the best of PSAO's knowledge, any PSAO Pharmacy (including PSAO Pharmacies currently in the network and new PSAO Pharmacies included in the network) location, pharmacy, pharmacist, subcontractor, or other personnel furnishing (or which will furnish) Covered Prescription Services to Members have been or will be (i) listed as debarred, excluded, or otherwise ineligible for participation in federal health care programs or (ii) convicted of a criminal felony. If at any time PSAO becomes aware of any violation of this representation and warranty, PSAO shall notify Administrator immediately in writing and shall prevent such personnel or pharmacy location from providing Covered Prescription Services to Members by requesting an immediate termination of such pharmacy location by Administrator.
- If PSAO or Network Pharmacy Provider itself becomes debarred, excluded or otherwise ineligible or if PSAO or Pharmacy has not taken the actions required of it in the preceding sentence, the Administrator may immediately terminate the Agreement upon written notice to PSAO without liability to Administrator or Administrator's Clients or take such other corrective or remedial actions as Administrator reasonably believes is appropriate.

Minimum credentialing requirements for pharmacies participating through a PSAO

- Network Pharmacy Provider is duly licensed in the applicable state of residence
- Network Pharmacy Provider has a DEA License (unless exception granted by Administrator)
- Network Pharmacy Provider maintains minimum liability insurance of \$1,000,000 per occurrence /\$3,000,000 aggregate (self-insurance not allowed for Pharmacies contracted through a PSAO)
- Owners of Network Pharmacy Provider or Network Pharmacy Provider are prohibited from participating in state and federal programs when found on either the Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE), as well as the General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS)
- Network Pharmacy Provider has no sanctions or limitations that would prohibit Network Pharmacy Provider from performing in accordance with the terms and conditions of the Agreement
- Network Pharmacy Provider meets the terms and conditions for participation in the applicable Agreement
- Pharmacist-in-Charge has all appropriate state and federal licenses
- Pharmacist-in-Charge and any Pharmacist or other personnel are prohibited from participating in federal/state programs when found on either the Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE), as well as the General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS)
- Pharmacist-in-Charge maintains minimum insurance levels specified by state
- Pharmacist-in-Charge has no restrictions, limitations or sanctions within the most recent three-years

Additional credentialing requirements for HI pharmacies participating through a PSAO

PSAOs contracted with Administrator for the Medicare Part D Home Infusion (MPD HI) Pharmacy Network are required to ensure each Network Pharmacy Provider associated with the MPD HI Pharmacy Network provides Infusion Therapy services and meet the definition of HI Pharmacy defined in this PM, as well as applicable CMS regulations.

CMS requires Medicare Part D Sponsors to validate the HI Pharmacy provides most Infusion Therapy Covered Prescription Services including the following requirements:

- Deliver Infusion Therapy Drug Products in a form which can be easily administered in a clinically appropriate fashion;
- Provide Infusion Therapy Part D Drug Products for both short-term acute care and long-term chronic care therapies;
- Ensure the professional services and ancillary supplies necessary for the provision of Infusion Therapy are in place before dispensing Infusion Therapy Drug Products, consistent with the quality assurance requirement for Medicare Part D Sponsors described in 42 CFR 423.153(c);
- Provide Infusion Therapy Covered Prescription Services within twenty-four (24) hours of discharge from an acute setting, unless the next required dose, as prescribed, is required to be administered later than twenty-four (24) hours after discharge; and
- HI Pharmacy has a “clean room” and “hood” capable of compounding sterile Drug Products.

In addition, Administrator encourages PSAOs to require each HI Pharmacy to:

- Ensure NCPDP dispenser type code indicates HI Pharmacy
- Update National Plan and Provider Enrollment System (NPPES) taxonomy code indicating HI Pharmacy <https://nppes.cms.hhs.gov/NPPES/Welcome.do>
- Obtain accreditation for providing Infusion Therapy services by an applicable accreditation organization

Chain pharmacies

In order for Chain Network Pharmacy Providers to participate, the Chain headquarters must submit a credentialing application, meet the Administrator credentialing requirements as specified in the credentialing application and be able to comply with the requirements of the Agreement, as well as Administrator PM. All Network Pharmacy Providers shall be licensed pursuant to the Administrator credentialing policy prior to submitting any Claims.

Administrator maintains the right to independently verify the credentials of any Network Pharmacy Provider, Network Pharmacy Provider Owner or Pharmacist, including requesting credentialing documentation directly from individual Network Pharmacy Providers, as well as performing on-site visits to establish the credentials of any Network Pharmacy Provider, Pharmacist or Owner of a Network Pharmacy Provider.

Additional state and plan requirements

All Network Pharmacy Providers contracting to participate may be subject to additional credentialing requirements to participate in particular plans or networks, including Medicaid and Medicare Benefit Plans. Administrator reserves the right to require additional credentialing information from a pharmacy, as applicable, in order for pharmacy to participate in such Benefit Plan.

In addition to credentialing, federal regulations apply to Network Pharmacy Providers, individuals or entities which have been excluded from federal program participation as evidenced by listing in the Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) or General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS).

Network Pharmacy Providers must check these lists upon hire and at least monthly to ensure employees working with Medicare and Medicaid Benefit Plans have not been excluded from federal program participation.

Network Pharmacy Provider staff can check these lists by using the following links:

- Office of Inspector General's (OIG) — U.S. Department of Health and Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) — <http://oig.hhs.gov/exclusions/index.asp>
- General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS) — <https://sam.gov/portal/SAM/#1>

Enhanced credentialing

CMS expects Medicare Part D Sponsors to perform an in-depth level of credentialing of pharmacies (i.e. enhanced credentialing) located in select geographic areas identified by CMS. Select pharmacy locations may be required to provide additional information, go through on-site pharmacy facility reviews/inspections prior to contracting and participation in some or all of Administrator's networks, including Medicare Part D, as well as Medicaid networks. enhanced credentialing applies to both directly and in-directly contracted pharmacy locations. Pharmacy, their PSAO, if applicable, agree to cooperate with Administrator or its designee with the enhanced credentialing process and acknowledge non-cooperation with such enhanced credentialing process may result in denial, exclusion or termination of network participation.

On-site pharmacy facility reviews

Administrator or its designee shall have the right, with or without notice, at reasonable times, to access, inspect, federal/state and review on-site the facilities, licenses and credentialing documents/records of Network Pharmacy Providers and pharmacy locations applying to participate in any of Administrator's Benefit Plans, as well as make copies of the licenses credentialing documents/records etc. maintained by pharmacy. Pharmacy agrees to cooperate with Administrator or its designee with the on-site pharmacy facility inspection and review and acknowledges non-cooperation with an on-site pharmacy facility review may result in denial or termination of network participation.

Quality related events

If as a result of a Member complaint, Prescriber response, audit or call center discussion, Administrator identifies a potential quality related event (e.g. medication misfill) and confirms with Network Pharmacy Provider the occurrence of such dispensing error. Network Pharmacy Provider will (i) review the information with the Member (ii) document the event based on Network Pharmacy Provider's internal policies and (iii) report the error to any appropriate regulatory agency (e.g. Institute of Safe Medical Practices (ISMP)/FDA Medwatch)). For paid Claims determined to have a quality related event, Administrator reserves the right to reverse the Claim or retract Claim payment.

Recall notices/expired medications

In response to all recall notices, the Network Pharmacy Provider maintains the responsibility to monitor recall releases, remove any impacted Drug Product stock from the shelves in a timely manner, notify any Members whom have received Drug Product and document actions taken. Additionally, Network Pharmacy Provider must maintain and document a process to ensure all expired Drug Products are removed from shelf stock routinely.

D. Pharmacies contracted through PSAOs

PSAOs are required to perform routine updates of the information regarding their Pharmacy locations in the NCPDP database. This ensures all pharmacies attached to the PSAO are credentialed, contracted and NCPDP maintains complete/accurate information. Administrator relies on the information in the NCPDP database and PSAO attests the information in the NCPDP database is accurate. Actively removing an association of a non-contracted pharmacy from your PSAO does not meet the credentialing requirements set forth by Administrator. PSAOs must remove such non-contracted pharmacy from affiliation in the NCPDP database. PSAO is also responsible for ensuring the integrity of any data and reconciling such information with NCPDP as required. Upon request, Network Pharmacy Provider is required to respond to Administrator within ten (10) business days of a request for documentation necessary to support claims processing or audits by Administrator or Benefit Plan Sponsor (or on behalf of Client or plan) and within thirty (30) days of receipt of Pharmacy Contact Verification forms or the Pharmacy Credentialing Request Form. Network Pharmacy Provider must submit accurate and complete documentation to Administrator within these time periods. PSAOs are further required to share all relevant information upon request from Administrator.

PSAOs shall provide Administrator with up to thirty (30) days prior Notice to adding new Pharmacy locations to their Agreement as Network Pharmacy Providers to provide Covered Prescription Services to Members, which any such new credentialed Pharmacy location shall satisfy and comply with all terms and conditions of this Agreement and subject to Administrator's sole and absolute discretion on approval.

 Additionally, because Administrator also relies on the lists of affiliated Pharmacies PSAOs provide to Administrator in Exhibit A of the Agreement or any other documents, PSAOs shall also immediately email Pharmacy location additions and deletions to **pharmacynetwork@optum.com**, as applicable.

Administrator and Benefit Plan Sponsor, at the sole and absolute discretion of each, may immediately limit or exclude any pharmacy location's participation as a Network Pharmacy Provider for applicable Benefit Plans, including from participation as a Network Pharmacy Provider under the terms and conditions of the Agreement.

Generally across all Benefit Plans, pharmacy locations may be excluded from participation as a Network Pharmacy Provider contracted indirectly with Administrator through a PSAO for the following, including but not limited to, reasons:

- Pharmacy location is a Mail Order Pharmacy or provides Covered Prescription Services to Members by Mailing
- Pharmacy location has been contracted independently with Administrator as a 340B provider
- Network Pharmacy Provider has been identified as distributing 340B Drug Products on behalf of a 340B Participating Entity through either a contract or ownership
- Pharmacy location does not maintain a valid DEA License or had its DEA license revoked
- Pharmacy network is state-specific
- Pharmacy network requires Medicaid ID number for participation
- Pharmacy is a compounding pharmacy or a qualified compounding pharmacy

 The above Pharmacy locations may contract directly with Administrator as an independent Network Pharmacy Provider. Such Pharmacy locations may email **pharmacycontracts@optum.com** to request contract.

Administrator shall notify PSAO as soon as reasonably practicable of Benefit Plan Sponsor's or Administrator's decision to disapprove a Pharmacy location for inclusion as a Network Pharmacy Provider in the Agreement or any Benefit Plan or a decision to suspend, revoke or terminate a Pharmacy location from participation in Administrator's or any Benefit Plan or network.

E. Confidentiality and proprietary rights

Network Pharmacy Providers agree to keep confidential and proprietary the following:

- Terms of the Agreement and documentation related to the performance of the Agreement, including, and without limitation, the Drug Product Formulary and MAC list;
- Methods of doing business, including the operations of the National Pharmacy & Therapeutics Committee and Administrator utilization review and quality assurance procedures and programs; and
- Any and all symbols, logos, trademarks, trade names, Marks, patents, inventions, copyrights, copyrightable material, trade secrets, personnel information, operating manuals, memoranda, work marketing programs, plans and strategies, operating Agreements, financial information and strategies, and computer software and other computer-related materials developed or used in Administrator business.

F. Medicaid; federal/state Medicare-Medicaid enrollee (MME) regulatory requirements

Particular states have certain Medicaid regulatory requirements, including specific provisions to be included in all Client and Benefit Plan Sponsor subcontractor Agreements (found in the Appendix). Particular states and CMS also have certain MME regulatory requirements, including specific provisions to be included in all Client and Benefit Plan Sponsor subcontractor Agreements (found in the Appendix). Pursuant to the terms of the Agreement, Network Pharmacy Provider shall comply with all applicable requirements in each applicable state, as determined solely by Administrator.

Texas Medicaid manual applicable to manage Medicaid plans

See Appendix

State-specific Medicaid program participation required

Certain state Medicaid plans may require participation in the state fee-for-service Medicaid program as well as a state Medicaid identification number. Medicare Part D Sponsors are required to follow applicable state Medicaid requirements.

Submission of clean claims via the POS system for 340B drug products

For all applicable 340B Drug Products, Network Pharmacy Providers must identify claims as follows: In field '420-DK' (Submission Clarification Code), a value of '20' indicating that the Network Pharmacy Provider has determined the Drug Products submitted to Administrator was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340B (a) (10) and those made through the Prime Vendor Program (Section 340B (a) (8)).

The 340B Drug Pricing Program requires drug manufacturers to provide covered out-patient Drug Products to certain eligible health care entities, known as covered entities, at or below statutorily defined discount prices (i.e. 340B Ceiling Prices). The purpose of the 340B Program is to lower the cost of acquiring covered outpatient Drug Products for selected health care providers, so they can stretch their resources to serve more Members or improve services. As a condition of continued participation in the Medicaid program, drug manufacturers must sign an agreement with the Secretary of HHS stating their product sales to the covered entities will be at or below the Ceiling Prices mandated by Section 340B. Failure to sell covered drugs at these prices could result in a manufacturer being prohibited from receiving payments for its products from the Medicaid program.

G. Retail and Mail Network Agreements

Network Pharmacy Providers in the retail network, without specific other arrangements (e.g. Specialty Credentialing and Compound Credentialing) shall maintain a breadth of acute and maintenance medications as to service routine Retail Pharmacy customers. This requires retail Network Pharmacy Providers maintain a variety of Drug Products as to service customers with a broad scope of therapeutic needs. Network Pharmacy Providers in the retail network or on a retail Agreement shall not solicit Members for mail delivery or deliver any Covered Prescription Services to Members by Mailing, except upon the advance written approval of Administrator or for limited single events (e.g. Member traveling), which approval may be refused in Administrator's sole discretion. Network Pharmacy Providers Mailing Covered Prescription Services must comply with all applicable state licensing laws for the states that the pharmacy is Mailing Covered Prescription Services into and participate in Administrator's Mail Order Pharmacy Network pursuant to a Mail Order Pharmacy Agreement.

Mail Order Pharmacies do not qualify for participation in the Administrator Retail Pharmacy network as a Retail Pharmacy. Network Pharmacy Providers locations that deliver Drug Products via Mailing, advertise Mailing or home delivery, must apply for a separate independent Mail Order Pharmacy Agreement. Mail Order Pharmacies must meet the following minimum qualifications for consideration in the network:

- Agree to the terms and conditions of the Mail Order Pharmacy Agreement
- Meet all credentialing requirements
- Maintain in good standing VIPPS Certification
- Maintain in good standing URAC Accreditation for Mail Order Pharmacies
- Licensed in the state the Mail Order Pharmacy is domiciled as well as meets all applicable state licensing requirements for any state that the pharmacy is Mailing Prescriptions into.

Meeting the above requirements does not guarantee participation in Network Pharmacy Provider network.

H. Compounding pharmacy participation in retail networks

Prohibited activities by retail pharmacies and compounding pharmacies

The following actions may result in termination of your Network Pharmacy Provider's Agreement and include, but not limited to:

- Ownership or partial ownership in a pharmacy by Prescriber or other Prescriber of Prescription Drug Products
- Compensation, both monetary or in-kind, either paid to or received from, any health care provider for referrals for prescribing a particular Compounded Drug or to a particular pharmacy
- Use of Form 1099 contractors to market pharmacy or particular Compounded Drug
- Submitting Compounded Drug Claims with ingredients manufactured or distributed from a non-FDA registered manufacturing facility and/or wholesaler not FDA registered or with no distribution locations within the USA
- Submitting Compounded Drug Claims with ingredients that include as a component of the a National Drug Code ("NDC") for a repackaged drug or a drug imported from another country without FDA approval
- Delivering Covered Prescription Services, including Compounded Drugs, by Mailing, unless specifically permitted to do so within the Agreement, Plan Specifications, amendment or in writing

- Advertising for obtaining Compounded Drugs delivered by Mailing, unless specifically permitted to do so within the Agreement, Plan Specifications, amendment or in writing
- Compounded Drug Claims with active ingredients which are not being used for a documentable medically accepted indication or for which the Prescriber is unable to provide adequate documentation for the basis of use. Submitting a Claim for a Compounded Drug when a manufactured Drug Product with an identical or similar formulation is available on the market
- Submitting prescribed ingredients of multi-ingredient Compounded Drugs as single-ingredient Claims
- Submitting prescribed individual ingredients of a Compounded Drug on separate Claims/directing Prescriber's to write Prescriptions for individual ingredients and requiring the Member to reconstitute the individual ingredients into a Compounded Drug
- Submitting a NDC that is not the NDC for the raw, bulk chemical, or Drug Product ingredient used in the Compounded Drug
- Splitting the days' supply or quantity of the Compounded Drug Claims to less than a thirty (30) day supply to circumvent Prior Authorization, dollar amount thresholds, quantity or Benefit Plan limits
- Splitting the days' supply or quantity of the Compounded Drug Claims to less than a thirty (30) day supply in order to gain additional reimbursement or Member Cost Sharing Amounts
- Refusing to dispense the Compounded Drug Prescription because of dispute over reimbursement
- Charging the Member more than the Cost Sharing Amounts provided by the POS System, including charging for non-covered ingredients
- Waiving Member Cost Sharing Amounts provided by the POS System
- Not using the NDC of the lowest cost AWP available on the market in the Compounded Drug
- Registration solely as a §503B, unless credentialed by OptumRx (Please see Compound credentialing section)
- Violating any Federal, State, or Local law regarding compounding, marketing, or dispensing Compounded Drug Prescriptions
- Acting as a central fill pharmacy for a pharmacy not contracted with Administrator
- Dispensing Compounded Drugs to a Member for the first time without verifying Prescriber or other Prescriber/Member relationship
- Dispensing Compounded Drugs without literature on file that supports the clinical/therapeutic value of the compound ingredients
- Dispensing or distributing Compounded Drugs which are not based on valid Prescriptions for individually-identified Members

I. Provide timely notice of demographic changes

Network Pharmacy Provider understands Administrator relies on the information about its Network Pharmacy Providers, as well as each Pharmacy location provided by NCPDP and directly to Administrator, therefore, Network Pharmacy Provider:

- Agrees to update in a timely manner all information in the NCPDP database whenever necessary as to ensure the information in the database is accurate as Administrator updates Network Pharmacy Provider profiles and may be displayed to Members via on-line or paper directories

- Unless otherwise specified, notifies Administrator in writing within ten (10) business days of any changes in the documentation and other information (e.g. Agreement, credentialing applications) provided to Administrator in connection with enrolling as a Network Pharmacy Provider and in any credentialing or quality management initiatives
- Immediately notifies Administrator and NCPDP of any sale, transfer or ownership or closure of the Network Pharmacy Provider and information documenting the availability, as well as contact information for continued retrieval on all Prescription documentation in accordance with contractual, as well as regulatory (e.g. Medicare Part D) requirements related to records retention
- Information includes, but is not limited to, changes in name, address, telephone number, fax number, email address, services, NPI, NCPDP, licensure information (e.g. DEA, state license), tax identification (ID) changes Medicaid ID, provider affiliation, ownership information, provider dispensing type.

It is the responsibility of Chain and PSAO organizations to ensure that the affiliated pharmacies associated with any applicable NCPDP Affiliation Code are effectively maintained accurate and updated timely with NCPDP in responses to changes in affiliated pharmacies.



Network Pharmacy Providers shall notify NCPDP of any updated information as soon as possible.

J. Involuntary disenrollment by benefit plan sponsor

Network Pharmacy Providers shall cooperate with Administrator and its Clients in gathering and/or providing information on Members for which the Benefit Plan Sponsor is seeking involuntary disenrollment for conduct considered abusive and disruptive to the point where service is disrupted for the Member or other Members. If Network Pharmacy Providers encounter abusive and disruptive Members, they should contact Administrator Customer Service using the contact information provided in Section II of this PM.

As a Network Pharmacy Provider, Administrator encourages that you keep notes and any documentation concerning abusive and disruptive contact as you may be asked to provide this information at the time you report abusive and disruptive Members.

K. National Plan and Provider Enrollment System (NPPES) Updates

Network Pharmacy Providers are strongly encouraged to update their information, including all taxonomy codes, on the National Plan and Provider Enrollment System (NPPES) at the following location: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>



The information on NPPES, including your pharmacy's taxonomy information, may be used for network and contract validation by Administrator, Clients and CMS.

L. Termination

Administrator may immediately terminate or suspend the Agreement or any applicable Addendum or Amendment (in whole or in part with respect to an applicable Client, network and/or Network Pharmacy Provider location) pursuant to business needs, Client-specific network design, for, in the opinion of Administrator, actions detrimental to the provider network(s) or for cause, regardless of the network in which the Network Pharmacy Provider participates for reasons including, but not limited to:

- Rejecting Members at the point of sale for a non-clinical reason, including to improve reimbursement;
- Implementing any systematic or other block of a Client's Benefits Plan(s);
- Any automated reversal processes;
- Attempts to steer or redirect Members to other coverage (including other discount card plans);
- Loss of required licensure by a Network Pharmacy Provider or individual location;
- Administrator reasonably believes that Network Pharmacy Provider or Pharmacist is or has been engaged in fraudulent activity of federal/state law;
- Network Pharmacy Provider's insurance required hereunder being canceled, lapsed, terminated or otherwise suspended without replacement coverage;
- Network Pharmacy Provider solicits or attempts to solicit or steer any client of Administrator to terminate its relationship with Administrator or to enter into a direct agreement with Network Pharmacy Provider;
- Network Pharmacy Provider engages conduct or communication(s), including, but not limited to, contacting or with any third party, including any Client, Plan and/or a Client or Plan's Member, which disparages Administrator;
- Any attempt by Network Pharmacy Provider to institute an automated reversal process;
- Any attempt by Network Pharmacy Provider to circumvent any security measure that is part of the POS System;
- Network Pharmacy Provider or Pharmacist provides substandard, inferior, contaminated or adulterated Drug Product(s) to any Member;
- Network Pharmacy Provider engages in Mail fulfillment in violation of the Agreement without Administrator's written authorization;
- Administrator determines in its sole and absolute discretion that Network Pharmacy Provider or Pharmacist has violated Administrator's policies and procedures, including without limitation those included in this PM in the provision of Covered Prescription Services;
- Governmental Authority directs Administrator to terminate its relationship with Network Pharmacy Provider;
- Network Pharmacy Provider is otherwise non-compliant with the PM;
- Network Pharmacy Provider violates any law or regulation relevant to performance under the Agreement and with the Network Pharmacy Provider's operations in general;
- Network Pharmacy Provider exceeds the scope of any license to use Administrator's or any Client's intellectual property;
- Network Pharmacy Provider misuses Administrator's or any Client's trade secrets.

In addition to the reasons for immediate termination or suspension set forth above and in the Agreement, Administrator may terminate or suspend Network Pharmacy Providers in accordance with state law notice requirements where applicable, from the network for reasons, which include, but are not limited to:

- Failure to meet and maintain credentialing requirements;
- Breach of any of the terms set forth in the Agreement, PM, Addenda and other Administrator documents;
- Any act in violation of any federal/state/local law, regulation or rule or any attempt to circumvent any security measure that is part of the Administrator system;
- Fraudulent Claim submission activity detected;

- Members charged amounts greater than the Benefit Plan Cost-Sharing Amount;
- Members are refused services as required by Agreement;
- Network Pharmacy Provider or any of its employees or subcontractors being listed on the OIG or GSA exclusion lists or is sanctioned under or expelled from participation in the Medicare, Medicaid or other government programs;
- Suspension or revocation of Network Pharmacy Provider's, Network Pharmacy Provider's or pharmacist's license or permit necessary to perform services under the Agreement;
- Network Pharmacy Provider or Pharmacist violates any federal/state law regarding the compounding, sale, dispensation, storage, packaging or use of any Drug Product, device, products or supplies dispensed to Members;
- Current or future affiliation with a pharmacy if a connection exists to a pharmacy that was terminated under any of the above-listed conditions associated with FWA (e.g. affiliation includes ownership or controlling interest in any percentage; holding of the physical real estate of the pharmacy location; a consultant relationship; employment of current and/or prior employees; immediate relatives such as spouses, children, parents or siblings; or otherwise obscuring ownership links).

In the event the Network Pharmacy Provider breaches any provision(s) of the Agreement or PM or the Agreement is terminated pursuant to the terms herein, to the fullest extent permitted by applicable law, Administrator shall be entitled to withhold payment, impose penalties and other measures as it deems fit, including penalties to address lost profits. Furthermore, in the event the Network Pharmacy Provider breaches any provision(s) of the Agreement, in addition to termination rights, Administrator shall have the right to:

- Suspend any and all obligations of Administrator under and in connection with the Agreement.
- Administrator suspension may include cancellation of checks, payment suspension of future cycle checks or restriction of claims submission. Administrator's ultimate remedies under this section include immediate termination of the Agreement.
- Impose reasonable handling, investigation and/or improper use fees and/or offset against any amounts owed to Network Pharmacy Provider under the Agreement (including amounts that are paid to Administrator on behalf of a plan sponsor) or under any other agreement between Administrator and Network Pharmacy Provider.

The Agreement may be terminated by Administrator upon prior notice with respect to any or all Network Pharmacy Provider's locations, according to the terms of the Agreement between the applicable parties or PM as applicable or such longer or shorter period of time as required by applicable Plan, Client or law. For the sake of clarity, in the event a particular Plan, Client or law requires a shorter or longer notice period, the Agreement will not terminate for that particular Plan, Client or law until the conclusion of that Plan's, Client's or law's notice period.

Notwithstanding anything to the contrary, at any time during the term of the Agreement, Administrator shall have the exclusive right to create any custom networks, which may exclude Network Pharmacy Provider or any of its individual locations, in its sole discretion. The termination of the Agreement as to any particular Pharmacy shall not prevent the subsequent termination of the Agreement as to any other Pharmacy or of the Agreement in its entirety.

The Network Provider Evaluation Committee (NPEC) will determine the extent to which a breach has occurred. NPEC will make a determination in regards to participation status or the need for further review and recommendations. Final determination will be made by the NPEC and may result in administrative action up to and including the termination of the Agreement or pharmacy network. All such occurrences will be placed in the Network Pharmacy Provider's credential file.

M. Alternative dispute resolution

Other than with respect to issues giving rise to immediate termination hereof or non-renewal hereof, the parties will work in good faith as set forth below to resolve any and all issues and/or disputes between them (hereinafter referred to as a "Dispute") including, but not limited to all questions of arbitrability, the existence, validity, scope, interpretation or termination of the Agreement, PM or any term thereof prior to the inception of any litigation or arbitration.

In the event a Dispute arises, the party asserting the Dispute shall provide written notice to the other party identifying the nature and scope of the Dispute to the other party sufficient for a reasonable person to be apprised thereof. If the parties are unable to resolve the Dispute within thirty (30) days after such notice is provided, then either party may request in writing a meeting or telephone conference to resolve the Dispute. At any such meeting or telephone conference, both parties shall have present its President, Vice President, Chief Financial Officer or Chief Officer. Either party may commence a Dispute Resolution in accordance with the rest of this section (or litigation if both parties waive arbitration) only if a representative of the party seeking to commence such litigation or arbitration certifies in writing that one of the following is true: (i) the Dispute was not resolved after faithfully following the procedures set forth above in this section or (ii) the other Party to the dispute did not fully comply with the procedures set forth above in this section.

If the party asserting the Dispute has satisfied the requirements of this section thereof, it shall thereafter be submitted to binding arbitration before a panel of three (3) arbitrators in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time-to-time (adr.org). All arbitrators must have at least ten (10) years of legal experience in the area of healthcare law.

Any arbitration proceeding under this Agreement shall be conducted in Los Angeles County or Orange County, California. Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one (1) year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the Dispute in any forum.

The arbitrators may construe or interpret, but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) will decide if any inconsistency exists between the rules of the applicable arbitral forum and the arbitration provisions contained herein. If such inconsistency exists, the arbitration provisions contained herein will control and supersede such rules.

Each party hereby consents to a documentary hearing for all arbitration Claims, by submitting the dispute to the arbitrator(s) by written briefs and affidavits, along with relevant documents; however arbitration claims will be submitted by way of an oral hearing, if any party requests an oral hearing within forty (40) days after service of the Claim and the party remits the appropriate deposit for fees, as well as the arbitrator compensation within ten (10) days of making the request.

Discovery permitted in any arbitration proceeding commenced hereunder is limited as follows:

No later than forty (40) days after the filing and service of a Claim for arbitration, the parties will exchange detailed statements setting forth the facts supporting the Claim(s) and all defenses to be raised during the arbitration and a list of all exhibits, as well as witnesses. In the event any party requests an oral hearing, no later than twenty-one (21) days prior to the oral hearing, the parties will exchange a final list of all exhibits, as well as all witnesses, including any designation of any expert witness(es) together with a summary of their testimony; a copy of all documents to be introduced at the hearing.

Notwithstanding the foregoing, in the event of the designation of any expert witness(es), the following will occur:

(i) all information and documents relied upon by the expert witness(es) will be delivered to the opposing party; (ii) the opposing party will be permitted to depose the expert witness(es); (iii) the opposing party will be permitted to designate rebuttal expert witness(es); and (iv) the arbitration hearing will be continued to the earliest possible date that enables the foregoing limited discovery to be accomplished.

The arbitrators will have no authority to award punitive, exemplary, indirect, special damages or any other damages not measured by the prevailing party's actual damages and may not, in any event, make any ruling, finding or award that does not conform to the terms and conditions of the Agreement.

The parties expressly intend that any dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the Dispute. The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

If the Dispute pertains to a matter which is generally administered by certain Administrator procedures, such as a quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Administrator before Administrator may invoke any right to arbitration under this section.

The decision of the arbitrator(s) on the points in Dispute will be binding and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event that any portion of this section or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this section or this Agreement. In the event any court determines this arbitration proceeding is not binding or otherwise allows litigation involving a dispute to proceed, the parties hereby waive any and all right to trial by jury in or with respect to such litigation, such litigation would instead proceed with the judge as the finder of fact.

For purposes of clarity, only the arbitration provisions in this section shall apply to any Network Pharmacy Provider terminations or other determinations made as to a Network Pharmacy Provider's status as a participating Network Pharmacy Provider in the Administrator network, pursuant to the NPEC review process as stated in the PM. The laws of the State of California and the laws of the United States (U.S.) applicable therein will govern as to the interpretation, validity and effect of the Agreement, the PM and any addendums.

This section shall survive any termination of the Agreement.

N. Confidentiality

Network Pharmacy Provider acknowledges as a result of the Agreement, PM and POS System, Network Pharmacy Provider and its employees, as well as agents may have access to Administrator's Proprietary Information, Client's Proprietary Information and Members' Confidential Information. The parties shall comply with all Laws applicable to the confidentiality, use, disclosure and maintenance of Members' personal information ("Confidential Information"). Except as required by law, Network Pharmacy Provider, on behalf of itself and its officers, employees, contractors and other representatives ("Representative(s)"), also agrees to treat as confidential and proprietary, and to take reasonable precautions and care to prevent unauthorized use and/or disclosure of the terms of this Agreement, as well as any other information relating to Administrator's business operations/services obtained in the performance

of this Agreement and not part of the public domain (“Proprietary Information”). Proprietary Information shall include Administrator’s pricing, programs, services, business practices, databases, software, layouts, designs, formats, processes, applications, systems, technology, files, compilations, exhibits, publications, protocols, information pertaining to Clients, Benefit Plans and formularies. All Proprietary Information remains the exclusive property of Administrator. Network Pharmacy Provider agrees to maintain the confidential nature of such Confidential Information and Proprietary Information and not to disclose such Confidential or Proprietary Information without the express written consent of Administrator. Network Pharmacy Provider shall only use Confidential or Proprietary Information in connection with the performance of this Agreement or any related Addendum Amendment, Exhibit or Schedule and shall not use the Confidential or Proprietary Information for any other purpose. Nothing in this section shall prohibit Administrator from discussing reimbursement or payment issues with a Client of Benefit Plan Sponsor. If Network Pharmacy Provider or its Representative receives a demand or request to disclose any confidential or proprietary information pursuant to the terms of a court order, subpoena, interrogatory or other legal process, such confidential or proprietary information may be disclosed to the extent required; provided (i) Network Pharmacy Provider promptly notifies Administrator of the existence, terms and circumstances surrounding such demand or request prior to the disclosure of any confidential or proprietary information and provides Administrator with a copy thereof (ii) Network Pharmacy Provider assists Administrator’s efforts to obtain, if and to the extent available, whatever protective order or other relief that Administrator desires to be obtained with respect to such demand or request and (iii) such Confidential or Proprietary Information is not disclosed more than three (3) days prior to the last date it may be disclosed without violating such court order, subpoena, interrogatory or other legal process, as such date may be modified by any order or other relief obtained. Upon termination of this Agreement, Administrator may request the return of its proprietary information in Network Pharmacy Provider’s control or possession or if such return is not feasible, Network Pharmacy Provider shall destroy such proprietary information and provide certification of such destruction. Network Pharmacy Provider further agrees that it shall be responsible for any breach of this section by its Representatives. Network Pharmacy Provider agrees that monetary damages would be difficult to ascertain in the event of any breach of this Section and that monetary damages alone would not suffice to compensate Administrator or Client for such breach. Network Pharmacy Provider agrees that in the event of a violation of this Section, without limiting any other rights and remedies, an injunction may be brought against Network Pharmacy Provider for breach or threatened breach of this Section, without the requirement to post bond. Network Pharmacy Provider submits itself to the jurisdiction of and agrees venue for purposes of damages of such injunctive relief are proper, in any federal/state court located in California; Network Pharmacy Provider shall reimburse Administrator for all of its costs and expenses (including, without limitation, reasonable attorneys’ fees) incurred by Administrator in connection with an actual or threatened violation of this section. This section shall survive expiration or termination of the Agreement and this PM.

O. Information management

Network Pharmacy Provider understands Administrator relies on the information in the NCPDP database regarding its pharmacy location(s) and attests that the information in the NCPDP database is accurate. Network Pharmacy Provider further agrees to update the information in the NCPDP database as necessary so as to ensure compliance with this section. Network Pharmacy Provider further understands that Administrator updates its files through weekly file feeds received from NCPDP or other nationally recognized provider data vendor, as determined by Administrator. Administrator updates and maintains all pertinent provider information including, but not limited to, demographics, NPI, licensure, Medicaid ID, provider affiliation, ownership, and provider dispenser type via these provider data feeds. Network Pharmacy Provider is required to make any system updates, including updating any relevant Network Pharmacy Provider information, through the Administrator provider data vendor.

To the extent Network Pharmacy Provider is owned, operated or controlled by or affiliated with a pharmacy benefit management business entity, Network Pharmacy Provider represents and warrants it has a firewall in place to protect any/all information received due to the receipt of an Agreement and protects from disclosure outside of the performance of its obligations under this agreement any information received that is proprietary with only those participants who are on a need to know basis to carry out such agreement provisions. Any intentional disclosure shall result in immediate termination and legal action as necessary.

P. Catamaran specialty pharmacy network addendum

Specialty Performance Guarantee Requirements

Pursuant to the Catamaran, an affiliate of OptumRx, Specialty Pharmacy Network Addendum, Network Pharmacy Providers providing specialty Covered Prescription Services in the network shall provide the required reports on a quarterly basis no later than thirty (30) days after the end of the quarter to **specialty.credentialing@optum.com**. Failure to provide the reports on a timely manner or failure to meet the performance metrics may constitute breach of Agreement and result in specialty pharmacy network termination and/or the imposition of the applicable financial penalty amounts set forth below or the maximum penalty amount of fifty thousand dollars (\$50,000) per quarter at Administrator's sole discretion.

Q. Insurance

Network Pharmacy Provider must at all times hold policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Network Pharmacy Provider and any of its personnel are insured against any Claim(s) for damages arising from the provision of Covered Prescription Services; such policies must have coverage, at a minimum, in the amount of one million dollars (\$1,000,000.00) per person and three million dollars (\$3,000,000.00) in aggregate, unless otherwise agreed to by Administrator or such greater amount required by law.

Network Pharmacy Provider must furnish copies of said policies upon enrolling as a Network Pharmacy Provider with Administrator and as requested by Administrator thereafter. Failure to maintain the minimum coverage may result in immediate termination as a Network Pharmacy Provider. Network Pharmacy Provider must notify Administrator immediately in writing if its insurance is canceled, lapsed or otherwise terminated. Failure to immediately notify Administrator in writing of any such termination of insurance coverage may result in immediate termination as a Network Pharmacy Provider. The requirements in this section apply to the extent permissible under applicable law.

Appendix A

Independent Pharmacy Credentialing Application

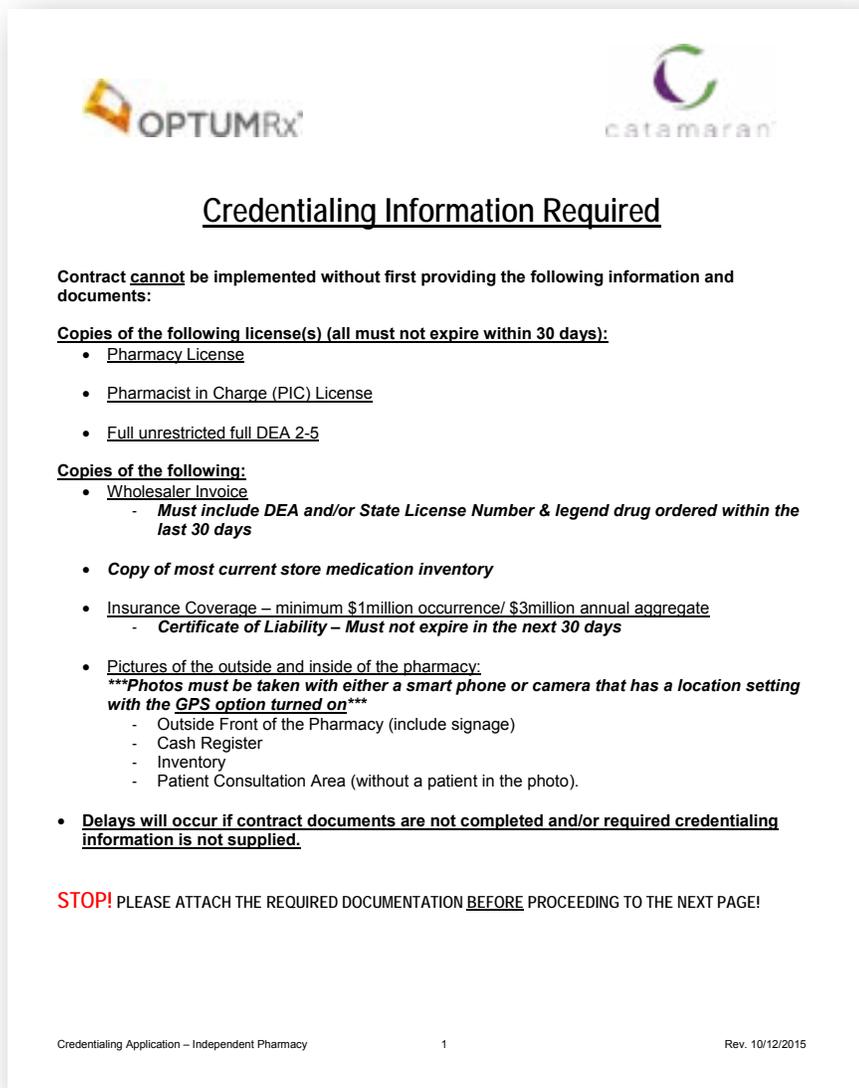


Only complete documents will be accepted.

For independent pharmacies

For example only — Independent pharmacies (Non-PSAOs affiliation)

Subject to change without notice at any time



OPTUMRx **catamaran**

Credentialing Information Required

Contract **cannot** be implemented without first providing the following information and documents:

Copies of the following license(s) (all must not expire within 30 days):

- Pharmacy License
- Pharmacist in Charge (PIC) License
- Full unrestricted full DEA 2-5

Copies of the following:

- Wholesaler Invoice
 - **Must include DEA and/or State License Number & legend drug ordered within the last 30 days**
- Copy of most current store medication inventory
- Insurance Coverage – minimum \$1million occurrence/ \$3million annual aggregate
 - **Certificate of Liability – Must not expire in the next 30 days**
- Pictures of the outside and inside of the pharmacy:
*****Photos must be taken with either a smart phone or camera that has a location setting with the GPS option turned on*****
 - Outside Front of the Pharmacy (include signage)
 - Cash Register
 - Inventory
 - Patient Consultation Area (without a patient in the photo).
- **Delays will occur if contract documents are not completed and/or required credentialing information is not supplied.**

STOP! PLEASE ATTACH THE REQUIRED DOCUMENTATION BEFORE PROCEEDING TO THE NEXT PAGE!

Credentialing Application – Independent Pharmacy 1 Rev. 10/12/2015

Appendix B

Independent Pharmacy Credentialing and Re-credentialing Application Fee



Only complete documents will be accepted.

For independent pharmacies

For example only — Independent pharmacies (Non-PSAOs affiliation)

Subject to change without notice at any time



The image shows a sample of a form titled "OPTUMRx CREDENTIALING APPLICATION and RE-CREDENTIALING FEE". At the top left is the OPTUMRx logo, and at the top right is the Catamaran logo. The text on the form reads: "OptumRx charges pharmacies a required initial Credentialing Application Fee and a subsequent Re-Credentialing fee to offset costs OptumRx incurs as a result of performing both the initial pharmacy credentialing and subsequent re-credentialing of pharmacy every three years ("Credentialing Fee")." It then states: "The pharmacy named below ("Pharmacy") hereby acknowledges, agrees and authorizes OptumRx to charge the Credentialing Fee by debiting Pharmacy's claims payment in the amount of \$150.00 for the initial credentialing and subsequent re-credentialing, as applicable." Below this is a line for "[INSERT COMPANY NAME]", followed by "Chain Code/NCPDP # _____". Then there are lines for "By: _____ (signature)", "Name: _____ (print name)", "Title: _____", and "Date: _____". At the bottom, it provides contact information: "If you have any questions, please contact the OptumRx credentialing department at (800) 613-3591, option 5, or via email at Pharmacycredentialing@optum.com. You may also fax documents to (877) 593-5368." The footer of the form reads "OptumRx Credentialing Application Fee 12.1.2013".

Appendix C

Affiliation Credentialing Application



Only complete documents will be accepted.

For chain pharmacies/PSAOs

For example only — Chain pharmacies/PSAOs (Non-independent affiliation)

Subject to change without notice at any time



OPTUMRx

Affiliation Credentialing Application

Section A: Affiliation Information

(DBA Name): _____

Corporate Name: _____

Other than the current name listed above, has pharmacy operated under any other trade or business name? Yes No

If Yes, please provide details and name(s): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

State Tax ID: _____ Website Address: _____

Federal Tax ID: _____ Affiliation Code(s) #: _____

Pharmacy Help Desk #: _____

Affiliation Type: Chain PSAO Franchise Combo Affiliation-owned Franchise/PSAO

Operate under a common db/a or banner name? Yes No

If Yes, please provide details and name(s): _____

If a PSAO or Franchise, please provide a copy of the template agreement that Pharmacies must execute to join your organization.

Payment Type: Source of Payment Check EFT
* For EFT set-up, please complete the information located on our website at www.optumrx.com/healthcareprofessionals/ef.

Payment Mailing Address (This address will also be used as the pharmacy's payment address)
 if mailing address is the same as the Affiliation corporate address, check here:

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Does your Affiliation currently use a third party reconciliation service? Yes No if so, who? _____

Pharmacy Notification/Communications Contact Information

Send Email/Fax communications: Send directly to Pharmacy Chain/PSAO to distribute to Pharmacies

If to chain/PSAO, send to:

Email: _____ Fax #: _____

Credentialing Application – Chain/PSAOs 1 Rev. 9/17/13

Appendix D

National council for the prescription drug programs (NCPDP) Submission clarification code

420-DK — Submission clarification code

Definition of field	Field format	Standard/version formats	Field limitations
Code indicating that the Pharmacist is clarifying the submission	9(2)	T, P, A	

Values

Code	Description
1	Not specified, default
2	No override
3	Other override
4	Lost Prescription — Cardholder has requested replacement of a Drug Product that has become lost.
5	Therapy change — Prescriber has determined that a change in therapy was required; either that the Drug Product was used faster than expected, or a different dosage form is needed, etc.
6	Starter dose — Previous Drug Product was a starter dose and now an additional Drug Product is needed to continue treatment.
7	Medically necessary — Drug Product has been determined by the Prescriber to be medically necessary.
8	Process Compounded Drug for approved ingredients
9	Encounters
10	Meets plan limitations — In-compliance with the program's policies and rules that are specific to the particular product being billed.
11	Certification on file — Guarantee's a copy of the paper certification, signed and dated by the Prescriber, is on file at the supplier's office.
12	DME replacement — Certification for a DME item replacing a previously purchased DME item.
13	Payer-recognized emergency/disaster assistance request — Override is needed based on an emergency/disaster situation recognized by the payer.
14	LTC leave of absence — Cardholder requires a short-fill of a Prescription due to a leave of absence from LTC facility.
15	LTC replacement Drug Product — Drug Products have been contaminated during administration in a LTC setting.
16	LTC emergency box (kit) or automated dispensing machine — Replacement supply for doses previously dispensed to the patient after hours.
17	LTC emergency supply remainder — Remainder of the Drug Product originally begun from an Emergency Kit.
18	LTC patient admit/readmit — New dispensing of a Drug Product due to the patient's admission or readmission status.
00	Other

Appendix E

Audit violations and discrepancy descriptions

NCPDP DATA CODE	ORx Code Description	NCPDP Description	ORx Audit Discrepancy Computation
1A-1	Recalculate Compound	Corrected Billing: Incorrect Billing Adjustment	Recoupment of only over charged portion
1A-2	Recalculate Compound	Corrected Billing: Incorrect Billing Adjustment	Full recoupment if pattern of abuse evident.
1A	Recalculate Compound	Corrected Billing: Incorrect Billing Adjustment	Recoupment of only overcharged portion.
1B	Recalculate Compound	Compound: Invalid use of the Compound Code.	Reverse & rebill as non-compound
1C	Recalculate Compound	Compound: Excessive ingredient cost per product submitted.	Recoupment of only over charged portion.
1D	Recalculate Compound	Compound: Incorrect ingredient product submitted.	Recoupment of only over charged portion.
1E	Recalculate Compound	Compound: Incorrect ingredient quantity submitted on one or more ingredients.	Recoupment of only over charged portion.
1F	Recalculate Compound	Compound: Ingredient quantities do not equal quantity billed.	Recoupment of only over charged portion.
4R	Invalid Rx	Prescription filled before date authorized.	Full recoupment if date of service before written date.
1G	Invalid Rx	Compound Prescription Work: Compounded Prescription please provide compound worksheet with pricing.	Full Recoupment.
1H	Invalid Rx	Incorrect date written /issue date submitted	Educational only.
1J	Invalid Rx	No Date on Rx	Charge back for initial dispensing and refills.
1K	DAW	Incorrect use of DAW code	Partial Recoupment: reverse and rebill claim with manual cost override at the generic cost (for the brand NDC)
1L	Mis-filled	Undocumented substitution	Full Recoupment
1M	Other	Billed brand and dispensed generic	Partial Recoupment: reverse and rebill claim to generic

NCPDP DATA CODE	ORx Code Description	NCPDP Description	ORx Audit Discrepancy Computation
4U	Days Supply	Overbilled quantity	No recoupment for initial fill or refills that occur at >75% (>50% for LTC) of calculated day supply of previous fill. Full recoupment of refills that are <75% (<50% for LTC) of calculated day supply.
1N	Days Supply	Incorrect Days Supply: Submitted days supply on claim is incorrect.	Educational
3K	Days Supply	Exceeds drug program dispensing limits.	Partial recoupment
1P	Invalid Rx	Missing / Invalid Prescriber Documentation ("PC", "CM", "P1 - P4" - Use Discrepancy Message to detail)	Full Recoupment
1Q	Invalid Rx	Missing / Invalid Patient Documentation ("PP" or "LG" - Use Discrepancy Message to detail)	Full Recoupment
1R	Wrong Drug	Different Drug Billed than written on order	
Full Recoupment			
1S	Wrong Drug	Different drug billed than dispensed	Full Recoupment
1T	Other	Incorrect Submission: Used Small Size NDC # for Larger Stock Size Dispensed	
2B	No Signature Log	Missing signature for proof of delivery	Full Recoupment
2C	No Signature Log	Incorrect date, Prescription or signature on proof of delivery (Signature Log) submitted	Full Recoupment
2H	Other	Other - must include additional information about the discrepancy must be reported in field 526-FQ (Additional Message Information)	Description in Discrepancy Description Column
2J	Wrong Member	Different Patient Name on Prescription	Full Recoupment
2L	Other	Possible clinical issue with gender/age/ drug - must include information about discrepancy in field 526-FQ (additional Message Field)	None. Educational for pharmacies only.
2M-1	Invalid DEA	Submitted Prescriber Identification is incorrect on Claim (Dummy DEA)	Full Recoupment if dummy DEA for CII through CV only
4B	Invalid DEA	Prescriber ID not valid	Full Recoupment for dummy DEA (CII through CV only)

NCPDP DATA CODE	ORx Code Description	NCPDP Description	ORx Audit Discrepancy Computation
2M	Wrong Doctor	Submitted Prescriber Identification is incorrect on claim.	Educational
2N	Invalid Rx	Doctor signature missing on Rx.	Full Recoupment
3N	Invalid Rx	No DEA # on Controlled Rx as required by Code of Federal Regulations	Full Recoupment
2P	Invalid Rx	No Prescriber on Prescription order	Full Recoupment
2R	Invalid Rx	Veterinary Prescriber inappropriate for Prescription	Full Recoupment
2T	Quantity	Quantity dispensed inconsistent with prescriber directions (titrated therapies)	Take back only overcharged portion
2U	Invalid Rx	Rx quantity is not complete, no quantity on Rx	Full Recoupment
2X	Quantity	Invalid quantity billed for single package item.	Full Recoupment
2V-1	Quantity	Undocumented Quantity Altered	1) Altered = Full Recoupment
2V-2	Quantity	Undocumented Quantity Changed	Educational Only: RPh needs to document physician approval to dispense greater quantity than originally prescribed & proportional reduction of refills.
2W-1	Quantity	Billed Quantity is different than quantity prescribed	1) If quantity is in excess of total prescribed quantity including refills, Recoupment of over charged portion
2W-2	Quantity	Billed Quantity is different than quantity prescribed	3) Full recoupment if pattern of abuse evident
2Y	Quantity	No documentation for dispensing a quantity less than prescribed.	None; educational for pharmacy only
2Z	Refill Too Soon	Refill too Soon	Full Recoupment
3A	Unauthorized Refill	Unauthorized/Undocumented Refill of Prescription	Full Recoupment
3D	Missing Prescription	Prescription Hardcopy Not Found	Full Recoupment
3E	Return to Stock	Prescription returned to stock but not reversed.	Full Recoupment
3F	Other	Rx does not meet all 3 of the CMS tamper-resistant Prescription requirements (MEDICAID)	Full Recoupment
3G	Invalid Rx	Prescription expired at time of dispensing.	Full Recoupment
3H	Mis-filled	Directions on Prescription different from computer record	Full Recoupment

NCPDP DATA CODE	ORx Code Description	NCPDP Description	ORx Audit Discrepancy Computation
3J	Invalid Rx	Prescription lacks specific, calculable directions (use as directed or missing directions)	Full Recoupment
3P	Invalid Rx	Missing/Invalid Long Term Care (LTC) Medication Administration Record (MAR).	Full Recoupment
3R	Invalid Rx	Missing/Invalid Long Term Care (LTC) Refill Request Form.	Full Recoupment
3S	Invalid Rx	Missing/Invalid Long Term Care (LTC) Patient Attestation Letter (letter indicating patient received and consumed the medication)	Full Recoupment
3X	Invalid Rx	Missing/Invalid Prescription Label.	Full Recoupment
4J	Invalid Rx	No strength designated on Prescription with more than one strength available.	Full Recoupment
4N	Invalid Rx	Prescriber does not have prescribing authority for medication dispensed.	Full Recoupment
4P	Unauthorized Refill	Refills exceed number allowed for controlled substances.	Full Recoupment
4T	Invalid Rx	Missing Prescription transfer information.	Full Recoupment
4K	Other	Incorrect Prescription Origin Code	Educational

Appendix F

Client-specific manual addenda

Please click the applicable link(s) to access the manuals:

- i. Amendment to Participating Pharmacy Agreement For the State of Texas CTRx pharmacy manuals
- ii. Community Partnership of Southern AZ
- iii. TX pharmacy provider manual for UnitedHealthcare Community Plans STAR, STAR+PLUS and CHIP products

Appendix G

Medicaid; federal/state Medicare-Medicaid enrollees (MME) regulatory requirements

OptumRx

The following state-specific appendices set forth certain regulatory requirements that Network Pharmacy Providers shall comply with, as applicable.

Click on the appropriate **bolded** link(s) to access currently active state-specific regulatory requirements:

1. Alabama (AL)

a. Medicaid Regulatory Requirements

2. Alaska (AK)

a. Medicaid Regulatory Requirements

3. Arizona (AZ)

a. Medicaid Program Medical Subcontractor

b. Children's Rehabilitative Services Medical Subcontractor

c. LTC System Program Medical Subcontractor

d. Medicaid Division of Developmentally Disabled Program Medical Subcontractor

4. Arkansas (AR)

a. Medicaid Regulatory Requirements

5. California (CA)

a. Medicaid Program Appendix Non-Medical Subcontractor

6. Colorado (CO)

a. Medicaid Regulatory Requirements

7. Connecticut (CT)

a. Medicaid Regulatory Requirements

8. Delaware (DE)

a. State Program Medical Subcontractor

9. Florida (FL)

a. Healthy Kids Program Medical Subcontractor

b. Medicaid Subcontractor

10. Georgia (GA)

a. Medicaid Regulatory Requirements

11. Hawaii (HI)

a. State Program Non-Medical Subcontractor

- 12. Idaho (ID)
 - a. Medicaid Regulatory Requirements
- 13. Illinois (IL)
 - a. Medicaid Regulatory Requirements
- 14. Indiana (IN)
 - a. Medicaid Regulatory Requirements
- 15. Iowa (IA)**
 - a. Hawk — i Program Medical Subcontractor**
- 16. Kansas (KS)**
 - a. Medicaid and CHIP Medical Subcontractor**
- 17. Kentucky (KY)
 - a. Medicaid Regulatory Requirements
- 18. Louisiana (LA)**
 - a. Medicaid and CHIP Provider**
- 19. Maine (ME)
 - a. Medicaid Regulatory Requirements
- 20. Maryland (MD)**
 - a. Medical Subcontractor**
- 21. Massachusetts (MA)**
 - a. Government Programs Appendix Provider**
 - b. Appendix**
- 22. Michigan (MI)**
 - a. Government Programs Subcontractor**
- 23. Minnesota (MN)
 - a. Medicaid Regulatory Requirements
- 24. Mississippi (MS)**
 - a. CHIP Appendix Medical Subcontractor**
 - b. CHIP Appendix Non-Medical Subcontractor**
- 25. Missouri (MO)
 - a. Medicaid Regulatory Requirements
- 26. Montana (MT)
 - a. Medicaid Regulatory Requirements

27. Nebraska (NE)**a. Medical Subcontractor**

28. Nevada (NV)

a. Medicaid Regulatory Requirements

29. New Hampshire (NH)

a. Medicaid Regulatory Requirements

30. New Jersey (NJ)**a. Medicaid, NJ Family Care Programs and NJ Medicaid Long Term Support Services Provider/
Subcontractor****31. New Mexico (NM)****a. Centennial Care Medical Subcontractor****32. New York (NY)****a. Medicaid, Family Health Plus and Child Health Plus Medical Subcontractor**

33. North Carolina (NC)

a. Medicaid Regulatory Requirements

34. North Dakota (ND)

a. Medicaid Regulatory Requirements

35. Ohio (OH)**a. State Program Provider****b. MME Rider**

36. Oklahoma (OK)

a. Medicaid Regulatory Requirements

37. Oregon (OR)

a. Medicaid Regulatory Requirements

38. Pennsylvania (PA)**a. Government Programs Administrative Subcontractor****39. Rhode Island (RI)****a. Medicaid Program Appendix Provider**

40. South Carolina (SC)

a. Medicaid Regulatory Requirements

41. South Dakota (SD)

- a. Medicaid Regulatory Requirements

42. Tennessee (TN)

- a. Medicaid Regulatory Requirements

43. Texas (TX)

- a. Medicaid Program Medical Subcontractor**
- b. Medicaid and CHIP Program Medical Subcontractor**

44. Utah (UT)

- a. Medicaid Regulatory Requirements

45. Vermont (VT)

- a. Medicaid Regulatory Requirements

46. Virginia (VA)

- a. Medicaid Regulatory Requirements

47. Washington (WA)

- a. State Programs Appendix Non-Medical Administrative Subcontractor**

48. West Virginia (WV)

- a. Medicaid Regulatory Requirements

49. Wisconsin (WI)

- a. Medicaid Regulatory Requirements

50. Wyoming (WY)

- a. Medicaid Regulatory Requirements

Appendix H

MAC State-Specific Requirements

Arkansas — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within seven (7) business days from the date-of-service on the applicable Claim. Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC, will provide the Network Pharmacy Provider the NDC the change is based on, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, and will make the MAC change applicable to all similarly situated Network Pharmacy Providers. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason, identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator and provide the name of the referenced national or regional pharmaceutical wholesaler operating in Arkansas.

California — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) business days following receipt of payment for the Claim upon which the appeal is based on. Administrator will investigate and resolve the MAC Appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC Appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question and will make the MAC change applicable to all similarly situated Network Pharmacy Providers. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Colorado — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within twenty-one (21) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC no later than one (1) day after the date of determination of the MAC appeal. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Florida — PBM must update the MAC pricing information at least every seven (7) calendar days.

Georgia — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) days of reimbursement of the initial Claim. Administrator will investigate and resolve the MAC appeal within fourteen (14) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question and will make the MAC change applicable to all similarly situated Network Pharmacy Providers. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Hawaii — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) business days following receipt of payment for the Claim the appeal is based on. Administrator will investigate and resolve the MAC appeal within fourteen (14) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Iowa — If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will allow for retroactive payment.

Kentucky — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within sixty (60) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within ten (10) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will allow Network Pharmacy Provider to reverse/rebill the particular Claim on appeal for retroactive adjusted reimbursement. If Administrator upholds the

MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Louisiana — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within seven (7) business days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, and will make the MAC change effective for all similarly situated Network Pharmacy Providers. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Maryland — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within twenty-one (21) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC no later than one (1) business day after the date of determination of the MAC appeal and will allow Network Pharmacy Provider to reverse/rebill the particular Claim on appeal and any subsequent similar Claims. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Michigan — Administrator will investigate and resolve the MAC appeal within ten (10) business days after the completed MAC Form is received by Administrator.

Minnesota — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fifteen (15) business days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC no later than one (1) business day after the date of determination of the MAC appeal. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Montana — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within ten (10) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the MAC change effective for all similarly situated Network Pharmacy Providers. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

New Mexico — Administrator will investigate and resolve the MAC appeal within fifteen (15) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC no later than one (1) business day after the date of determination of the MAC appeal and will make the adjustment applicable to all similarly situated Network Pharmacy Providers.

New York — Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC effective on the day of resolution of the MAC appeal and will make the adjustment applicable to all similarly situated pharmacies in this state that are within the network. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

North Carolina — Administrator must update the MAC pricing information at least every seven (7) calendar days.

North Dakota — Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC effective on the day of resolution of the MAC appeal and will make the adjustment effective for all similarly situated Network Pharmacy Provider providers in this state within the network.

Ohio — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within twenty-one (21) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC effective on the day of resolution of the MAC appeal, as well as make the adjustment applicable to all similarly situated pharmacies in this state that are within the network. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Oklahoma — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) business days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within ten (10) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will make the change in the MAC and will permit the challenging pharmacy to reverse/rebill the Claim in question, and make the MAC change effective for each similarly contracted Oklahoma provider. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Oregon — Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC effective on the day of resolution of the MAC appeal and will make the adjustment applicable to all similarly situated pharmacies in this state that are within the network. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Tennessee — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within seven (7) business days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, and will make the MAC change applicable to all similarly situated Network Pharmacy Providers. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Texas — For Medicaid Claims, Administrator will investigate and resolve the MAC appeal within ten (10) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the MAC change effective for all similarly situated Network Pharmacy Providers. For commercial fully insured and ASO non-ERISA Claims, for a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) days from the date of the initial Claim submission. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Utah — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within fourteen (14) business days after the completed MAC Form is received by Administrator. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Vermont — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within ten (10) days after the completed MAC Form is received by Administrator.

Virginia — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within fourteen (14) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will update the MAC within five (5) days of determination. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Washington — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within thirty (30) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within seven (7) business days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will change the MAC no later than one (1) business day after the date of determination of the MAC appeal and will make the adjustment effective for all similarly situated pharmacies in this state that are within the network. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Wisconsin — For a MAC appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within twenty-one (21) days after the completed MAC Form is received by Administrator. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will update the MAC no later than one day after the date of final determination. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator.

Appendix I

Client-specific information

OptumRx

Delaware Medicaid clean claim payment

Administrator will reimburse Network Pharmacy Provider for each Clean Claim no later than thirty (30) days after Administrator's receipt of the Clean Claim, and contingent upon Benefit Plan Sponsor funding.

Louisiana Bayou Health Medicaid Program

Requires the Network Pharmacy Provider directory on its website for public access to reflect the following data elements for all pharmacies participating in the Louisiana Bayou Health Medicaid Plan administered by Administrator:

- Telephone numbers for each pharmacy location
- Any non-English languages spoken
- Hours of operation, including pharmacy locations that are open 24-hours
- Identification of pharmacy locations that provide vaccine and/or delivery services

In order to meet this state requirement to make this information available to Louisiana Bayou Health plan Members, Administrator is requiring that these data elements be updated for each of your pharmacy locations in the NCPDP database.

NCPDP database updates and edits can be made by accessing ncpdponline.org.

All Prescriptions filled for Louisiana Bayou Health Members and submitted to Administrator that are not picked up within fourteen (14) calendar days must be reversed via the POS System, as well as returned to stock.



- Requires a \$0.10 per Claim pharmacy "provider" fee which must be submitted in NCPDP field 481-HA (flat sales tax submitted) on all Claims. NCPDP determined this field is appropriate even though this is a fee, not a tax. The response amount of the "provider" fee will be reflected in NCPDP field 558-AW (flat sales tax paid).

Federal regulations require Medicaid to verify that Members receive the services for which Medicaid has provided reimbursement. Medicaid periodically samples Members to verify that they did receive the Prescriptions that were billed by pharmacies. Louisiana Medicaid conducts random reviews of paid Claims to verify proof of services and may require documentation of Prescription receipt. These reviews are in addition to any audit performed by Administrator pursuant to the Agreement.

Kancare Medicaid Program

Requires the disclosure of ownership of all Network Pharmacy Providers, including the disclosure of the:

- Names and addresses of all owners, Pharmacist-in-Charge/Pharmacy Managers; and
- Nine (9) digit Social Security Numbers for all owners, Pharmacist-in-Charge/Pharmacy Managers

BIN/PCN

Client/Plan name	BIN	PCN
AARP MedicareComplete insured through UnitedHealthcare; UnitedHealthcare MedicareComplete	610097	9999
AARP MedicareRx Plans insured through UnitedHealthcare; AARP MedicareRx Enhanced Prescription Drug Plan (PDP); AARP MedicareRx Preferred PDP; AARP MedicareRx Saver Plus PDP	610097	9999
AARP Welfare Plan	610097	9999
Community and State (C&S) MMP of Ohio - Medicare	610097	8500
Community and State (C&S) MMP of Ohio - Medicaid	610494	9999
Care Improvement Plus	610097	9999
Commercial	610494	9999
Community Health	610613	2417
Erickson Advantage	610097	9999; 8888
FLEXSCRIPTS	017472	FLEXRX
Florida Share of Cost	610494	2222
Golden State Medicare	610097	9999
HealthESystems	012874	-----
Hewlett Packard	610097	9999
John Deere Company	610097	9999
Legacy Innoviant Commercial	610127	02330000; 01960000;
UntiedHealthcare Community Plan of Maryland Medicaid	610084	RXSOLPRD
Maryland Senior Prescription Drug Assistance Program SPDAP (2013 claims; 2014 claims);	610097	8888; 9999
Medalist Rx	016580	-----
Medica	610097	9999
Medicaid	610494	4444

Non-Part D Plans (MA and Retiree Drug Subsidy [RDS] only); UnitedHealthcare Medicare Complete Essential (HMO); AARP MedicareComplete Plus Essential (HMO-POS); AARP MedicareComplete Essential (HMO); AARP MedicareComplete Choice Essential (PPO); UnitedHealthcare MedicareDirect Essential (PFFS)	610494	9999
NYCTA	610097	8888
Part D WRAP Plans	610097	8888
Pennsylvania Public School Employees' Retirement System PSERS	610097	9999
Physicians Health Choice Basic (HMO)	610494	9999
Physicians Health Choice Total (HMO); Physicians Health Choice Select (HMO SNP)	610097	9999
Preferred Care Partners/The Villages	610097; 610494	9999
Raytheon COB	610127	04000001; 04000002; 04000004
Sierra Medical Advantage Prescription Drug MAPD – Health Plan of Nevada	610097	9999
State Health Plan of North Carolina (SHPNC)	610097	8888
Symphonix	610097	9999
TeamStar Medicare Part D	610097	9999
U.S. Virgin Islands Senior Citizens Affairs Pharmaceutical Assistance Program	610097	8888
UnitedHealthcare Dual Complete (HMO SNP) in Wisconsin	610097	9999
UnitedHealthcare Dual Complete Preferred (HMO SNP) in Tennessee	610097	9999
UnitedHealthcare Employer and Individual	610279	9999
UnitedHealthcare Employer- Contraceptive Services Only	610279	CONTRAC
UnitedHealthcare Chronic Complete	610494	9999
UnitedHealthcare Community Plan	610494	9999
UnitedHealthcare Community Plan Coordination of Long-Term Services (CoLTS)	610094	9999
UnitedHealthcare Community Plan of Ohio Medicaid	610494	4141
UnitedHealthcare Dual Complete (DH, DH-POS, DP, RDP)	610097	9999; 8888
UnitedHealthcare Dual Complete (HMO SNP)	610097	9999
UnitedHealthcare Dual Complete (HMO SNP) in Michigan	610097	9999
UnitedHealthcare Dual Complete (HMO SNP) in New York	610097	9999
UnitedHealthcare Group Medicare Advantage	610097	9999; 8888
UnitedHealthcare Medicaid Supplemental Plan	610494	2222
UnitedHealthcare MedicareRx for Group PDP	610097	9999; 8888

UnitedHealthcare Nursing Home Plan (IH, IH-POS, IP)	610097	9999
UnitedHealthcare Senior Care Options in Arizona	610097	9999
UnitedHealthcare Senior Care Options in Massachusetts	610097	8500
UnitedHealthcare SignatureValue Commercial	610494	9999
UnitedHealthcareMedicareDirect Rx (PFFS)	610097	9999

Unitedhealthcare

Pharmacy help desk service contact information



Hours of operation: 24 hours a day, 7 days a week, 365 days a year

For Member information regarding Benefit Plan **exclusions, disease therapy management (DTM) programs or other customer service issues**, please contact the Administrator using one of the following:

UnitedHealthcare Medicare Advantage Prescription Drug Plan (MA-PD):

- Telephone: **1-877-889-6510**
- Telephone Device for the Hearing Impaired (TDHI): **1-866-394-7218**

UnitedHealthcare Medicare Prescription Drug Plan (PDP):

- Telephone: **1-877-889-6481**
- Telephone Device for the Hearing Impaired (TDHI): **1-866-394-7218**

UnitedHealthcare Community Plan (Medicaid Programs):

- Telephone: **1-888-306-3243**
- Telephone (Community and State): **1-877-305-8952**
- Telephone (Medicare-Medicaid Plans (MMP) Plans): **1-877-889-6510**
- Telephone Device for the Hearing Impaired (TDHI): **1-866-394-7218** or **1-877-305-8952**

UnitedHealthcare Community & State (C&S) — (Medicaid PA):

- Telephone: **1-800-310-6826**
- Telephone Device for the Hearing Impaired (TDHI): **1-877-449-6611**
- Fax: **1-866-940-7328**

UnitedHealthcare Employer & Individual:

- Telephone: **1-888-290-5416**
- Telephone: **1-800-788-7871** (OptumRx Carve-Out)
- Telephone Device for the Hearing Impaired (TDHI): **1-800-498-5428**

UnitedHealthcare direct member reimbursement contact information

Carrier	UHCACIS01		UHCPRIM01	UHCUHC101
Platform	ACIS		PRIME	ACIS
Alt ID	Non-standard	Standard	Standard	Standard
Submitted group	UH+7 digit policy#	UHealth1	UHC	UHealth1
BIN	610279	610279	610279	610279
PCN	9999	9999	9999	9999
DMR mailing address	P.O. Box 29044 Hot Springs, AR 71903			

 Changes to this year's Medicare Part D Formulary, for the following Benefit Plans, will be posted on the websites listed below.

Please Note:

This list is not all-inclusive, but a sample only.

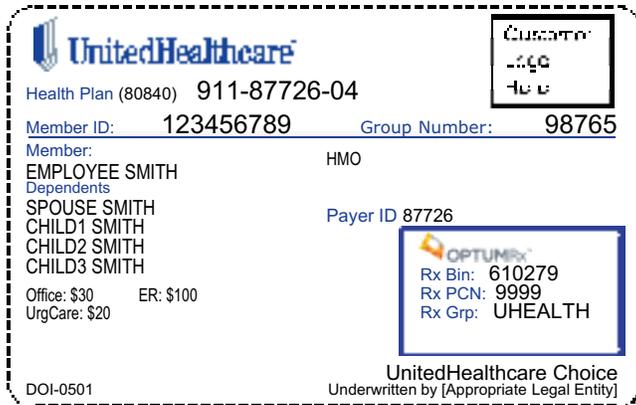
Plans	Websites
AARP MedicareComplete AARP MedicareRx Enhanced AARP MedicareRx Preferred	https://aarpmedicareplans.com/landing/medicare-advantage-plans.html?wtredirect=aarpmedicarecomplete.com&WT.mc_id=880341
Erickson Advantage	http://ericksonadvantage.com/
IBT (International Brotherhood of Teamsters)	http://teamstarpard.com/
Golden State Medicare Health Plan	http://goldenstatemhp.com/
PSERS (Pennsylvania Public School Educators' Retirement System)	http://hopbenefits.com/
Sierra MAPD Plan	http://sierrahealthandlife.com/
UnitedHealthcare Community Plan	http://uhcommunityplan.com/
Symphonix Health Plan	https://symphonixhealth.com/

Troubleshoot Member ID Cards

For instances when a Member does not have an ID card, please see the following:

Situation: Member does not have an ID card	Step 1	Step 2	Step 3	Step 4
<p>Person is at the pharmacy and has no proof of coverage but states they are currently enrolled.</p> <p>Member may present generic marketing materials that were provided with the inquiry kits.</p>	<p>1) E1 transaction initiated to determine eligibility; this is done by the Pharmacist</p> <p>(a) Eligibility validated; Pharmacist processes Prescription</p> <p>(b) Eligibility not validated or Pharmacist unable to access E1, move to step 2</p> <p>Note: An E1 transaction can be initiated with the Member's Social Security Number (SSN) or Member's ID.</p>	<p>Pharmacist contacts the Pharmacy Help Desk using the contact information provided in Section II of this PM.</p> <p>(a) Pharmacy Help Desk validates eligibility and Claim is processed</p> <p>(b) Unable to validate eligibility, move to step 3</p>	<p>Pharmacy Help Desk directs pharmacy to refer Member to applicable call center number located on Member ID card.</p>	<p>1) Call center confirms eligibility; Member eligibility entered real-time into system; Member advises Pharmacist to fill Prescription.</p> <p>2) Unable to confirm eligibility or eligibility has been denied; person pays retail for Drug Product; fourteen (14) day window to allow for online processing at pharmacy when eligibility issue resolved or person to submit a paper Claim for reimbursement.</p> <p>3) Person unwilling to pay retail, Prescription not filled.</p>
<p>Person is at the pharmacy and has an acknowledgement or confirmation letter with an enrollee number and states that they are enrolled.</p>	<p>1) E1 transaction initiated to determine eligibility or Pharmacist attempts to process Claim online; this is done by the Pharmacist.</p> <p>(a) Eligibility validated; Pharmacist processes Prescription online</p> <p>(b) Eligibility not validated or Pharmacist unable to access E1, move to step 2</p>	<p>Pharmacist contacts the Pharmacy Help Desk using the contact information provided in Section II of this PM.</p> <p>(a) Pharmacy Help Desk validates eligibility and Claim is processed</p> <p>(b) Unable to validate eligibility, move to step 3</p>	<p>Pharmacy Help Desk directs pharmacy to refer Member to applicable call center number located on Member ID card.</p>	<p>1) Call center confirms eligibility; Member eligibility entered real-time into system; Pharmacist fills Prescription.</p> <p>2) Unable to confirm eligibility, eligibility pending, eligibility has been denied, or a disenrollment was processed; person pays retail for Drug Product; fourteen (14) day window to allow for online processing at pharmacy when eligibility issue resolved or person to submit a paper Claim for reimbursement.</p> <p>3) Person unwilling to pay retail, Prescription not filled.</p>

UnitedHealthcare Sample Member ID Cards






Health Plan (80840) 911-87726-04

Member ID: 123456789 Group Number: 98765

Member: EMPLOYEE SMITH HMO

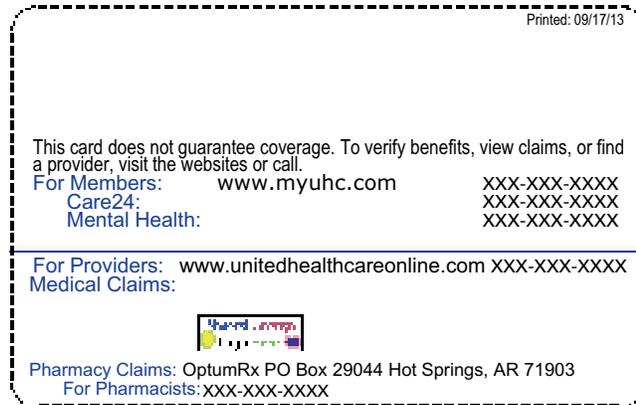
Dependents: SPOUSE SMITH Payer ID 87726
 CHILD1 SMITH
 CHILD2 SMITH
 CHILD3 SMITH

Office: \$30 ER: \$100
 UrgCare: \$20



UnitedHealthcare Choice
 Underwritten by [Appropriate Legal Entity]

DOI-0501



Printed: 09/17/13

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.

For Members: www.myuhc.com XXX-XXX-XXXX
 Care24: XXX-XXX-XXXX
 Mental Health: XXX-XXX-XXXX

For Providers: www.unitedhealthcareonline.com XXX-XXX-XXXX
 Medical Claims: XXX-XXX-XXXX



Pharmacy Claims: OptumRx PO Box 29044 Hot Springs, AR 71903
 For Pharmacists: XXX-XXX-XXXX

Vaccine and immunization administration

Commercial

When your pharmacy administers vaccines listed in the annual flu season communication for eligible commercial plan Members, reimbursement is based on an all-inclusive fee which encompasses the administration fee, ingredient cost and dispensing fee.

- UnitedHealthcare contracts for select vaccines and immunizations; not all Clients participate in the Administrator Vaccine Program.

Medicaid (UnitedHealthcare Community Plans)

• Processing requirements when you provide and administer the vaccine

When your pharmacy provides and also administers the vaccine, please populate the NCPDP field 438-E3 (Incentive amount submitted) field to submit for the \$10 administration fee and populate field 439-E4 (Reason for service code) with "MA."

• Administration fee-only claims

If the vaccine was obtained through special program such as Vaccines for Children, you may submit a Claim for just the administration fee by submitting the Claim as usual, including the administration fee and changing your U&C amount to \$0.01. You will be reimbursed \$10.01.

Medicare Part D

In order to be reimbursed the contracted administration fee of \$20 for Part D eligible vaccine products, the Network Pharmacy Provider must (i) submit the contracted fee in the incentive fee section of the Claim and (ii) submit a DUR/PPS Code Counter of "1" and Profession Service Code of Medication Administration (MA).

-  To participate in Administrator Vaccine and Immunization programs, please email pharmacycontracts@optum.com

Catamaran

Local Pick-up Program

If the Network Pharmacy Provider participates in the Catamaran local pick-up program, Network Pharmacy Provider will be responsible for Drug Product fulfillment to eligible Members under Prescription benefit plans to be identified by

Catamaran. Drug Product fulfillment is the dispensing of Prescriptions to eligible Members, including, but not limited to, the following specific activities: receiving bulk shipment of Prescriptions (excluding refrigerated items) already filled, labeled and packaged by one of Catamaran’s licensed Network Pharmacy Providers; signing and returning to Catamaran the packing slip confirming receipt of the order; storing the Prescription orders in a designated location; handing Prescription orders to eligible Members or their authorized representatives who pick them up at the dispensing Network Pharmacy Provider; offering to counsel eligible Members about the Prescription orders being dispensed and having a licensed Pharmacist providing counseling to those who accept the offer to counsel; and maintaining any records required by law in connection with its services. This process may not be available in all states and may vary state-by-state in accordance with applicable state laws.

Appendix J

Catamaran state-specific provider manual addenda

Medicaid: Federal/State Medicare-Medicaid enrollees (MME) regulatory requirements

Additional state-specific appendices set forth certain regulatory requirements that Network Pharmacy Providers shall comply with, as applicable. All additional state-specific appendices are detailed on catamaranrx.com (access to the portal will require proper credentials).

Commercial requirements

Additional state-specific exhibits set forth certain requirements that Network Pharmacy Providers shall comply with, as applicable. All additional state-specific exhibits are detailed on catamaranrx.com (access to the portal will require proper credentials).

Click on the appropriate link(s) to access state-specific regulatory requirements listed below:

1. Florida Regulatory Addendum
2. Georgia Regulatory Addendum
3. Hawaii Regulatory Addendum
4. Illinois Regulatory Addendum
5. Kentucky Regulatory Addendum
6. Maryland Regulatory Addendum
7. Massachusetts Regulatory Addendum
8. New Jersey Regulatory Addendum
9. New York Regulatory Addendum
10. New York Addendum to the Participating Provider Agreement
11. North Carolina Regulatory Addendum
12. Ohio Regulatory Addendum
13. South Carolina Regulatory Addendum
14. Texas Regulatory Addendum
15. Washington Regulatory Addendum