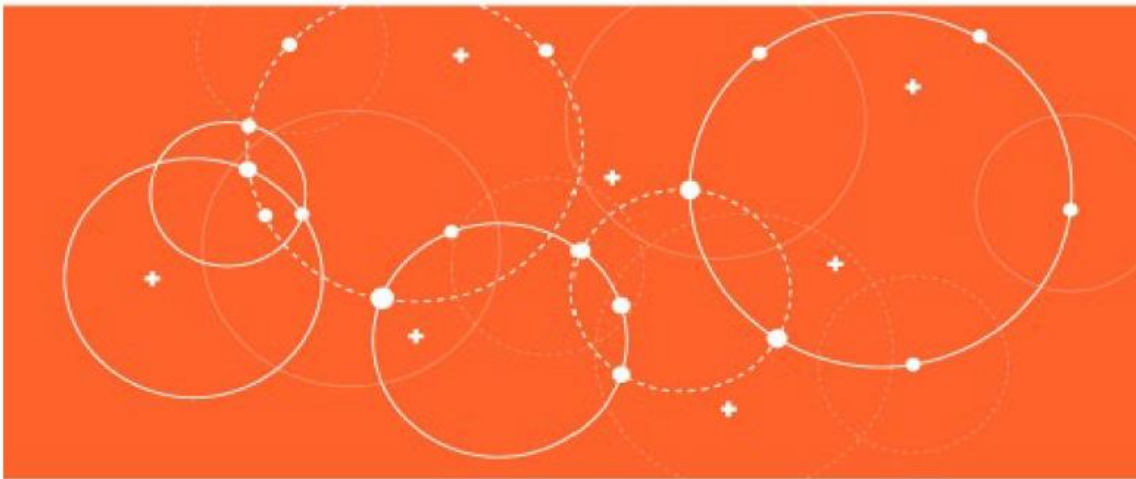




2024

Pharmacy Provider Manual



I. 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 participating pharmacy provider network agreements, including, but not limited to the Pharmacy Network Agreement, Specialty Pharmacy Network Agreement and Provider Agreement (hereafter “Agreement,” which includes the PM and Provider Agreement alike).

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, including if the Agreement is with a Pharmacy Services Administrative Organization (PSAO). As a Network Pharmacy Provider, including if affiliated with a PSAO in the NCPDP database, 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.

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 or PSAO 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.

In the event that Administrator or any of its affiliate acquires a company, whether by merger, stock acquisition or asset acquisition (the “Acquired Company”), that has a pharmacy network agreement with Network Pharmacy Provider in effect at the time of the acquisition (the “Pre-Existing Agreement”), Administrator may, in its sole discretion, require that Network Pharmacy Provider restate the Pre-Existing Agreement to be substantially similar to this Agreement or terminate the Pre-Existing Agreement without penalty to Administrator, and provide Covered Prescription Services to the Acquired Company in accordance with the terms of this Agreement, effective as of the date of the acquisition or other mutually agreed upon date. In the event that Administrator determines, in its sole discretion, that the Preexisting Agreement should continue in accordance with its terms, Network Pharmacy Provider’s provision of services to the Acquired Company shall remain subject to the terms and conditions of the Pre- Existing Agreement.

NOTE: THIS PM (INCLUDING THE AGREEMENT) CONTAINS PROVISIONS GOVERNING THE RESOLUTION OF DISPUTES RELATING IN ANY WAY TO THE PARTIES’ RELATIONSHIP, INCLUDING THAT ALL SUCH DISPUTES BE RESOLVED EXCLUSIVELY THROUGH BINDING ARBITRATION. THESE PROVISIONS ARE DESCRIBED IN SECTION IX.M. (“Alternative Dispute Resolution and Arbitration”) OF THIS PM. PLEASE CAREFULLY REVIEW THOSE PROVISIONS.

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.
- The Provider Manual will be updated periodically, including without limitation through fax blast communications. Updates to the Provider Manual are effective thirty (30) days, or such later date as may be specified by Administrator, after being posted to the website or by any other means as determined solely by the Administrator. If a Network Pharmacy Provider submits one or more claims to Administrator after the effective date of any update, the terms of the update are

accepted by the Network Pharmacy Provider and are considered part of the Agreement.

- 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 and encouragement to reach out for additional assistance (see Section III) Notable information for routine use by Network Pharmacy Providers

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II. 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, OptumRx Administrative Services, LLC and any subsidiaries or affiliates which provide pharmacy benefit services.

Agreement:

Administrator's contractual arrangements with Network Pharmacy Providers, including, but not limited to the Pharmacy Network Agreement, Specialty Pharmacy Network Agreement, Provider Agreement, or other Agreement entered into on behalf of Clients and Payers.

Average State Price (ASP):

ASP is defined as a manufacturer's average sales price of a drug for all purchasers in the United States in a calendar quarter net of all rebates, discounts, and other price concessions divided by the total number of units of the drug sold by the manufacturer in that same quarter. ASP is based on the CMS published Medicare Part B fee schedule and provided multiplier (e.g. ASP is 6% above Medicare Part B fee schedule as communicated by CMS).

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 or Plan:

Benefit or Plan coverage provided to Payer's or Clients' Members for Covered Prescription Services which are subject to the Agreement and this Provider Manual, including without limitation any Commercial, Administrative services- only, self-insured, Medicaid, Medicare Advantage, MA-PD Plan or Medicare Prescription Drug Plan, third-party administrator, and multiple employer trusts or other government programs. Benefit Plan or Plan may also include worker's compensation plans, no-fault auto insurance plans, hospice plans 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 & Medicaid Services (CMS):

CMS is a federal agency within the United States Department of Health & 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)/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 may not be considered a Clean Claim and may be subject to an additional Claim processing charge. Prescription 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 may not be considered a Clean Claim. For example, a claim that utilizes atypical directions for drug products which conflict with typical drug information available in pharmacy systems for patient education without medical necessity and of limited clinical value. 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, hs, 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 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:

Prescription Drug 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.

Date of Service (DOS):

The date on which a provider administers a professional service(s) to a patient.

Delivery of Medication:

Network Pharmacy Provider is authorized to utilize pharmacy employees under a W-2 status to deliver, at no additional cost to the Member, covered prescription services to Members within a 100-mile radius of the pharmacy’s physical location. In unique and/or limited single events, Administrator reserves the right to grant a waiver to deliver beyond the designated limits for covered prescription services delivery.

Dispensing Physician:

A practitioner authorized by law to prescribe drugs may dispense such drugs to his or her patients in the regular course of his or her practice in compliance with State laws and regulations as a convenience to the patient.

Drug Enforcement Administration (DEA):

Federal agency that licenses Prescribers and Pharmacies to prescribe and/or dispense controlled substance Drug Products.

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.

ePrescription (eRx):

Program that presents Members eligibility, formulary and Prescription history to the Prescribers in real-time at point of care to enable accurate, error-free electronic prescribing of the Prescriptions directly to the Pharmacy. Physician EMR capability is integrated with ePrescribing services by providing Member and Benefit Plan information in real-time to the Prescriber.

ePrior Authorization (ePA):

Electronic transmission of information between the Prescriber, and payer to determine whether or not the PA is granted. Administrator has advanced ePA capabilities which allow physicians to submit PA questions electronically and, in many cases, get immediate coverage determinations.

Faxblast / Pharmacy 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.); Federal law enacted to control the ways that financial institutions handle nonpublic information of individuals/consumers.

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 & Human Services (HHS):

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

UHC Individual and Family Plan (IFP):

Segment of plans created as a result of the Affordable Care Act, as stated in Title 45 of the Code of Federal Regulations (CFR) §156. Effective in 2014, IFP offers standardized health insurance plans to individuals, families and small businesses. These plans are referred to as "Exchanges", "Health Insurance Marketplace" or "IFP" plans.

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.

Indian Health Services, Tribal or Urban Indian Health or I/T/U:

Retail pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization as defined in Section 4 of the Indian Health Care Improvement Act, 25 U.S.C. 1603. These pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP) dispenser type code of 8. Program authorized through Title V of the Indian Health Care Improvement Act which provides access to hospitals, health clinics and pharmacies in IHS or tribal service delivery areas.

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.

Level of Effort (LOE):

Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a provider to perform a professional service.

Long-term-care (LTC) Facility:

Skilled nursing 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 that 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 shipping 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.

MedicalRx Specialty Provider Network (MSPN):

MSPN is an opt-in network of contracted medical providers administering select infused/assisted injection drugs. In this network, these select drugs traditionally covered on the medical benefit are now covered on the pharmacy benefit.

Medicare Advantage Benefit Plans (MA):

CMS-approved MA plans sponsored, issued or administered by Clients including, but not limited to, private fee-for-service plans as defined in the MA rules. MA plans cover hospital and physician services, Drug Products not covered by Medicare Part D Benefit Plans and Durable Medical Equipment (DME) (including, but not limited to, diabetic supplies such as test strips and lancets) typically covered under Medicare Parts A or B.

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 CMS and the states for managing the health benefits of 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.

Medication/Drug Day Supply:

The number of days the supply of medication should last based on dosage and treatment schedule.

Medication Quantity:

Indicates amount of drug/medication dosage units required to fill the prescription and satisfy the day supply.

Member:

Individual/Person, including an injured worker, 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 Association of Boards of Pharmacy (NABP):

The National Association of Boards of Pharmacy is an international association which assists Member boards and jurisdictions in administering its pharmacist license transfer and pharmacist competence assessment programs for the purpose of ensuring public health.

National Drug Code (NDC):

The NDC is defined as a universal product identifier for human drugs in the United States, presented as a unique 10-digit or 11-digit, 3-segment number. The 3 segments of the NDC identify: the labeler, the product, and the commercial package size.

NABP Digital Pharmacy Accreditation:

The NABP Digital Pharmacy Accreditation, formerly VIPPS, accredits websites offering pharmacy services, and recognizes the need to help safe and legitimate pharmacies with an internet presence stand out against the ever-growing list of rogue websites.

NABP Drug Distributor Accreditation:

The NABP Drug Distributor Accreditation, formerly VAWD, is for facilities engaged in the act of wholesale drug distribution.

National Council of Prescription Drug Programs (NCPDP):

Organization that develops and promotes industry standards and business solutions that improve patient safety and health outcomes, while also decreasing cost. National Provider Identification (NPI) number: Unique ten (10) digit identifier assigned to health care providers to use when submitting a HIPAA standard transaction.

National Provider Identifier (NPI):

The NPI is a HIPAA Administrative Simplification Standard. The NPI is a unique 10-digit identification number for covered health care providers (e.g., physicians and other clinicians) and facilities (e.g., hospitals and laboratories). The NPI is used by all health plans for administrative and financial transactions.

Network Compound Credentialing Program (NCCP):

A compound credentialing program which validates any Network Pharmacy Provider who wishes to dispense Compounded Drugs containing Active Pharmaceutical Ingredients (API) and API-like (e.g. excipients) ingredients through a credentialing process to application, documentation review and on- site Pharmacy visits.

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 ePrescription.

Pharmacist:

An individual appropriately licensed in their respective State(s) to dispense and sometimes prescribe Drug Products to Members.

Pharmacy or 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 Administrative 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.

Place of Service (POS):

Specifies the entity or setting in which a professional service was provided.

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 or processor.

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 phone or online submission by the Member, Member's appointed/authorized representative and/or Prescriber to review Drug Product(s) which requires a prior authorization. Benefit Plan's approved criteria, clinical guidelines or other professionally recognized standards of practice as well as Member's diagnosis, drug product justification or other pertinent information are utilized for the review. Network Pharmacy Providers may not act in the capacity of a Prescriber without an appointment of representation.

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-identify with NCPDP as any of the following: Mail Order Pharmacy (dispenser type code "5") or Specialty Pharmacy (dispenser type code of "15")

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 Pharmacist or Drug Products used to treat chronic and potentially life-threatening diseases.

Specialty Management Access Portal (SMAP):

An electronic billing tool that medical providers can utilize for submitting drug claims to OptumRx. The tool is also used for drug coverage verification, prior authorization requirements, and claims activity.

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 Pharmacist.

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.

Trial Claim:

A real time evaluation of benefit coverage which also results in notification of prior authorization requirements, provider reimbursement, and member cost share.

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 may be considered noncompliance.

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.

III. 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.

Note: With the growth of OptumRx, information may be specific to a legacy BIN/PCN at this time. Please refer to the BIN/PCN information to determine which specific contact information to use.

A. Pharmacy Help Desk Service



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

Pharmacy Self-Service Website

Access the OptumRx Pharmacy Website: professionals.optumrx.com

- The OptumRx Pharmacy website is a secure online environment designed to assist pharmacies with everyday tasks and reduce time spent calling the Pharmacy Help Desk.
- Visit the Pharmacy eServices – Self-Service page to:
 - Search for a patient information
 - Submit refill too soon overrides for vacation, lost or stolen medications and mail order delay
 - View patient eligibility, claim history and prior authorization status
 - Search for drug pricing and alternative medication options specific to patient formulary
 - On the home page, you will find additional information on how to register and use the site.
- For technical website issues, call 1-855-505-8114 between 7:00 AM and 7:00 PM, Monday – Friday.

Pharmacy Help Desk

To speak with a Pharmacy Help Desk agent, please contact one of the following toll-free numbers:

- **OptumRx List 1 RxBINs Pharmacy Help Desk:** 1-800-788-7871
- **OptumRx List 2 RxBINs Pharmacy Help Desk:** 1-800-880-1188
- **OptumRx List 3 RxBINs Pharmacy Help Desk:** See contact information provided in the Workers' Compensation and auto no-fault section of this PM.
- **UHC Individual and Family Plan (except CO) Pharmacy Help Desk:** 1-844-569-4143
- **UHC Individual and Family Plan - Colorado Pharmacy Help Desk:** 1-844-368-8732
- For Plans not listed under UHC in the Appendix, use the pharmacy number on the Member's ID card
- Telephone Device for the Hearing Impaired (TDHI): 1-866-498-5428

B. Prior Authorization (PA) Service



OptumRx List 1 RxBINs — Hours of operation:

- Monday–Friday, 5 a.m. to 10 p.m. (Pacific Time);
- Saturday, 6a.m. to 3 p.m. (Pacific Time)

OptumRx List 2 RxBINs — 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 List 1 RxBINs:**
 - Telephone: 1-800-711-4555
 - Telephone (Innoviant): 1-866-565-7723
- **OptumRx List 2 RxBINs:**
 - Telephone: 1-800-626-0072
 - Fax (Oral): 1-866-511-2202
- **OptumRx List 3 RxBINs:** See contact information provided in the Workers' Compensation and auto no-fault section of this PM.

C. Pharmacy Network Contract Department



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

For questions related to contracting or to request a contract, please contact us at:

Independent Contracting
11000 Optum Circle
Eden Prairie, MN 55344

Fax: 1-844-305-2623
Email: independent.contracting@optum.com

Web: professionals.optumrx.com

Please see Contact information provided in the Workers' Compensation and auto no-fault section of this PM.

D. MAC Appeals Contact Information



Hours of Operation: Monday – Friday, 6 a.m. to 4 p.m. (Pacific Time)

To review the summary and guidelines for appealing MAC prices / pharmacy reimbursement, as well as downloading the form for submitting appeals, please visit the Pharmacist section of the OptumRx Health Care Professionals Portal or contact us using one of the following:

- **OptumRx Lists 1 & 2 RxBINs**
 - Telephone: 1-800-613-3591 Ext. 9
 - Fax: 1-866-285-8652
 - Email address: MAC@optum.com
- **OptumRx List 3 RxBINs:** See contact information provided in the Workers' Compensation and auto no-fault section of this PM.

Website: <https://professionals.optumrx.com/resources/manuals-guides/appeals-submission-guide.html>

E. Pharmacy Network Credentialing Department



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

For an initial independent retail pharmacy credentialing application, credentialing application status or questions related to credentialing, please contact us:

Pharmacy Network Credentialing Department
11000 Optum Circle
Eden Prairie, MN 55344

Email: pharmacycredentialing@optum.com

Please see Contact information provided in the Workers' Compensation and auto no-fault section of this PM.

F. Provider Forms and Documents

Prior Authorization (PA) Guidelines and Formulary change requests can either be submitted online or by fax or mail. Other provider forms and documents are also available online. It is important to refer to the following website for current documents, forms, manuals, payer sheets and other communications - professionals.optumrx.com.

Please contact us using one of the methods listed below. Note - 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.

Online:

- To review PA guidelines: [Prior Authorization Guidelines and Procedures \(optumrx.com\)](https://professionals.optumrx.com)
- For other available online forms: [Forms \(optumrx.com\)](https://professionals.optumrx.com)

Mail or fax:

Please address the applicable department.

- For formulary change requests – Attn: Clinical Formulary Operations.
- For PA guidelines – Attn: Clinical Programs.

OptumRx List 1 RxBINs

11000 Optum Circle
Eden Prairie, MN 55344
Fax: 1-949-474-4237

OptumRx List 2 RxBINs

OPTUMRX
P.O. BOX 5252
LISLE, IL 60532
Fax: 1-866-511-2202

Provider forms and documents available online:



[Forms \(optumrx.com\)](https://professionals.optumrx.com) – 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.



[Health Care Professionals Portal \(optumrx.com\)](https://professionals.optumrx.com) – It is important to refer to this web-portal for current documents, forms, manuals, payer sheets and other communications.

G. Pharmacy Communications

Periodically, Administrator communicates updates on procedures, formularies, provider manual, plan, etc., via Pharmacy Communication. These communications are sent electronically to the contracted entity (Independent pharmacy, Chain, Group Purchasing Organization, or Pharmacy Services Administrative Organization) corporate office via facsimile (i.e. fax) process or email. To request copies of previously sent Pharmacy Communications, please contact us below:

E-mail address: pharmacyprovidercommunications@optum.com

IV. Sample Member Identifications (ID) Cards

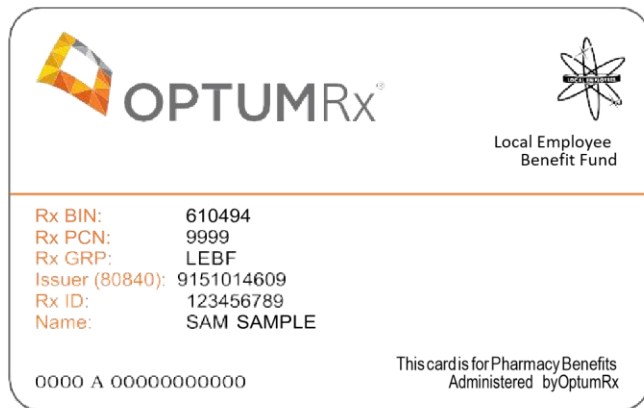


Eligible Members receive an identification (ID) card containing information that helps our Network Pharmacy Providers submit Claims accurately and completely. In accordance with CMS requirements, and/or state regulatory requirements, a Network Pharmacy Provider must submit Claims to the Medicare Part 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).

Member may also present their ID card using an electronic device such as a phone or a tablet and may also have processing information included on an electronic prescription.

Except for discount card program, and to the extent as required by applicable law, an Administrator or a Client, 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.

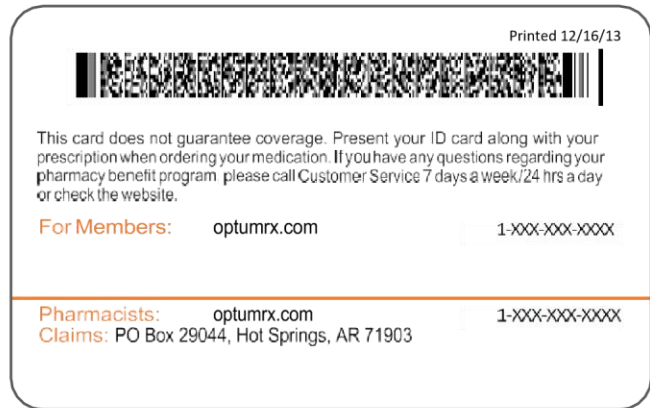
Below are samples of Member ID cards representing two different Benefit Plan Sponsors. This is a sampling only and is not an all-inclusive list. Member ID cards may be added, deleted or amended at any time. For further information/examples, please see the Appendix H.



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

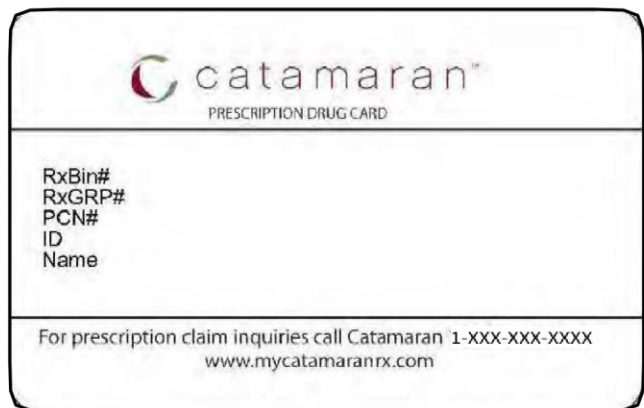


Printed 12/16/13

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

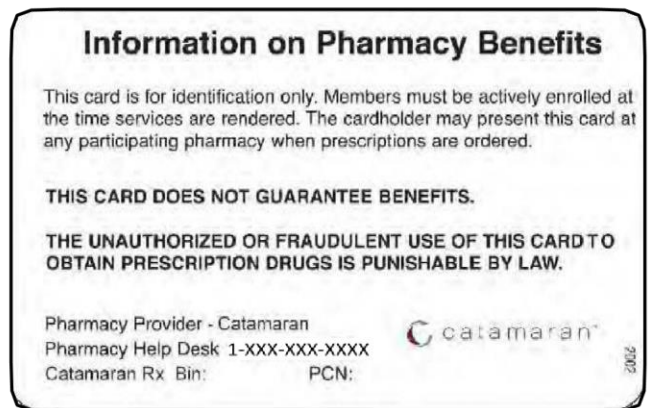
Pharmacists: optumrx.com 1-XXX-XXX-XXXX
Claims: PO Box 29044, Hot Springs, AR 71903



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.

V. 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, so it is particularly important to correctly code the pharmacy claims according to the NCPDP standards, in order to submit pharmacy Claims to ensure proper payment and application of Cost-Sharing Amounts, COB and other related pharmacy services.

Claims submitted must be supported by a valid prescription order that complies with all applicable federal, state and local laws, regulations and rules for professional practice. The pharmacy is responsible for verifying that a prescription was written based on a valid Prescriber/Member relationship.

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). Claims should be reversed within fourteen (14) days, as soon as reasonably practical or as specified by a particular governing requirement. All prescriptions not received by a Member must be reversed within fourteen (14) days from original submission. Claims not reversed within fourteen (14) days are subject to audit and may be collected through the pharmacy audit process to ensure claims accuracy. In the event of a Partial Fill - when the entire quantity of the prescription is intended to be filled, but the pharmacy has a stock shortage and provides the Member with a partial amount - the completion amount of the medication must be fulfilled within fourteen (14) days. If the pharmacy is unable to fulfill the entire prescription within fourteen (14) days, the claim must be readjudicated to reflect the amount dispensed to the Member.

Federal programs the Administrator supports:

- 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 & 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 – Centers for Medicare and Medicaid Services (CMS) Preclusion List.
- 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 Reject Code 71 or A1 — “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 may not submit a Claim for a Prescription not fully compliant with applicable Federal and State prescribing laws and regulations.

CMS Requirement to Submit Claims

In accordance with CMS requirements, and/or state regulatory requirements, a Network Pharmacy provider must submit claims to the Medicare Plan or its intermediary whenever the ID card is presented or on file at the pharmacy, unless the Member expressly requests that the claim not be submitted.

Network Pharmacy providers should contact the OptumRx Pharmacy Help Desk or refer to this Provider Manual for additional claims processing assistance for the following:

- Prior Authorization, DUR or other resolvable rejections
- Pharmacy and/or member has questions about the claim copay – including Medicare Part B copays for Dual Eligible Medicare Advantage Plans

- Pharmacy has a question about reimbursement rate

Unless a Medicare Member specifically requests that the claim not be submitted to their Medicare Plan, Network Pharmacy providers should refrain from collecting cash for claims that have, or could have been, adjudicated at POS and/or Medicare Part B copays that should be billed to Medicaid.

Emergency Use Authorization (EUA) situations

There may be circumstances when medications enter the US Medication Channels not by a full approval by the FDA, but through an Emergency Use Authorization (EUA). This EUA is intended to provide access to medications on an expedited basis and usually in response to a critical public health crisis. Examples have occurred with medications for treatment of COVID-19 patients during the coronavirus pandemic.

When medications are available to pharmacies through the EUA process, the FDA will issue very specific guidance about the appropriate conditions for the medication use. Pharmacies are expected to fully comply with the exact letter of the requirements in any EUA documents. It is important to note that pharmacies will be held responsible to meeting the requirements of the most recent EUA guidance as the FDA may, as new evidence becomes available, update the conditions of the EUA.

Additionally, CMS may issue guidance on reimbursement for EUA medications. In situations where a federal agency has issued reimbursement guidance, those rates will be utilized barring any different pricing information provided by OptumRx.

As medications move from EUA status to full approval, the normal rules of prescription processing, rather than any EUA guidance, will take precedence.

Federal Regulations for Schedule II Drugs

Pursuant to the Comprehensive Addiction Recovery Act 2016 (CARA), a pharmacy may partially fill a schedule II prescription under the following circumstances:

- it is not prohibited by state law;
- the prescription is written and filled in accordance with this title, regulations prescribed by the Attorney General and state law;
- the partial fill is requested by the patient or the practitioner that wrote the prescription and the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

Remaining portions of partially filled prescription for CII may be filled and shall be filled no later than 30 days after the date which the prescription is written. For emergency situations as described in section (a) the remaining portions may be filled and shall be filled not later than 72 hours after the prescription is issued. 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 Prescriber's written prescription.

Network Pharmacy Providers must also comply with federal/state laws and regulations that govern dispensing of Schedule II Drug Products and should be aware that state laws and regulations may require additional/more stringent practices relating to the partial filling of Schedule II drug prescriptions. This may include any copayment, cost-sharing, or benefit arrangements.

For LTCF pharmacies, 21 CFR § 1306.13(b) allows a pharmacist and prescribing practitioner have the corresponding responsibility to assure controlled substance is for a terminally ill patient. Pharmacist must record on the prescription the patient is "terminally ill" or an "LTCF patient." A prescription that is partially filled without these notations is deemed to be in violation of the act. Each partial fill the dispensing pharmacist will record on the back of the prescription (or on another appropriate record, uniformly maintained, and readily retrievable) the date of the partial fill, quantity dispensed, remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.) The total quantity of the CII dispensed in the partial fillings must not exceed the total quantity prescribed. CII prescriptions for LTCF or patients with a medical diagnosis documenting terminal illness

shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of medication.

Quantity Prescribed and Incremental Fill on Schedule II Medications Effective Date: September 21, 2020
Effective September 21, 2020, OptumRx required pharmacies to submit the Quantity Prescribed (460-ET) field on all pharmacy claims for Controlled Substance II (C-II) prescriptions as required by HHS. If the Quantity Prescribed (460-ET) field is left blank, the pharmacy will receive the following reject message: "ET 569 - Qty Prescribed Required."

This supports guidance from CARA and the DEA which aim to identify incremental fills on C-II drugs. Pharmacies must enter the Quantity Prescribed, do not send 0 (zero) as a quantity.

The NCPDP has provided guidance on the use of the Quantity Prescribed (460-ET) field to identify incremental fills for C-II drugs.

- NCPDP identifies an incremental fill as a quantity of a C-II medication dispensed is less than the full amount prescribed and occurs at the request of the prescriber or the Member.
- This differs from the partial fill - when the entire quantity of the prescription is intended to be filled, but the pharmacy has a stock shortage and provides the Member with a partial amount, then completion amount of the medication.

Note: Incremental fill is NOT a substitute for partial fill and should not be used for drug shortage but only when the member/prescriber requests lesser quantity than prescribed.

- An incremental fill transaction will be required to be conducted at the same pharmacy, using the same prescription number and same pharmacy service provider type. Note: the number of refills authorized by the prescriber for C-II prescriptions must always be entered as 0 (zero). CARA regulations prohibit refills on C-II medications and should not be submitted by the pharmacy.
- The pharmacy will receive a message via the POS system stating the incremental fill balance of medication remaining on the prescription. This balance cannot exceed the total quantity prescribed by the physician and will result in a rejected claim.
- Incremental fill copayment proration may apply where required by State or by the insurance plans.

OptumRx has performed additional review of the regulations and determined that State law should be reviewed for initial incremental fills in instances where the State regulation allows longer than 30 days (retail) or 60 days (LTC/terminally ill) from the date written for a C-II prescription to be filled. The initial incremental fill claim should not reject even if it is beyond the 30 days (or 60 days) from the date written.

There is currently no override to the existing OptumRx reject if an initial incremental fill is submitted beyond 30 days, and this is within the State regulation for date written. OptumRx is working to update the software but until then, pharmacies are advised to dispense the prescription as written or work with the prescriber to change the prescribed quantity on the claim so that the dispensed quantity equals the quantity prescribed. Alternatively, a new prescription with a written date not greater than 30 days of the fill date will be required.

Pharmacy communications and payer sheets can be found online: [Health Care Professionals Portal \(optumrx.com\)](https://www.optumrx.com).

Online Processing Window to Submit Electronic Claims

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

Commercial Claims:

- Thirty (30) days or 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:

- Retail pharmacies: Ninety (90) days or longer period as required by law or federal regulations.
- LTC pharmacies: Ninety (90) days or longer period as required by law or federal regulations.

Medicaid Claims:

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

IFP Claims:

- One-hundred-eighty (180) days or longer period allowed by the Benefit Plan or as required by law or Government Authority.

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 may 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.
- Prompt pay requirements for Medicaid MCO's with a contract do not differ from the standard state requirements, inclusive of Health Exchanges.



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 the address (PO Box) listed on the back of the members ID Card or:

Optum Rx
PO Box 650287
Dallas TX 75265

National Drug Code (NDC) Number

Network Pharmacy Providers should always submit the eleven (11) 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 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 an 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://npiregistry.cms.hhs.gov>.

For IFP and Medicare: If permitted by State law, when a claim does not require a prescription or a physician's authority to delegate prescribing is authorized, such as an OTC drug or a vaccine administered by a pharmacist, submit the Pharmacist's Type 1 NPI as the Prescriber ID.

If the claim rejects for Reject Code 619: "Prescrib Type 1 NPI Req'd" and the Type 1 NPI is confirmed to be valid, resubmit with submitted clarification code 42 (Presc ID validated).



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 non-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 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 an 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. In accordance with the aforementioned Federal regulations, select clients have opted to reject Schedule II products billed with refill codes greater than [###]. NCPDP Rejection Code 17- M/I Fill Number will be returned with messaging 'Maximum of 0 Refills Exceeded'.

Taxonomy

Prescribing individuals 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). The process of determining prescriptive authority should include multiple components.

- Prescriber must have legal authority to prescribe specific Drug Products.
- All prescriptions must also be within the scope of their practice.
- Prescriber must have a valid taxonomy code which reflects their prescriptive authority for the specific Drug Products they dispense.

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 reject code:

Reject Code	NCPDP Description
56	Non-matched prescriber ID

DEA Number

The DEA publishes and makes available several manuals which are intended to provide guidance/information on the requirements of the Controlled Substances Act and its implementing regulations. Section IX of the DEA's Pharmacist's Manual defines who may issue a valid Prescription for a controlled substance. A Prescription for a controlled substance may only be issued by a Physician, dentist, podiatrist, veterinarian, mid-level practitioner or other registered practitioner who is:

1. Authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice; and
2. Registered with DEA or exempted from registration.

To be compliant with the federal guidance, Network Pharmacy Provider must validate the Prescriber's DEA number is authorized to prescribe controlled substances. Claims submitted without the correct prescribing authority for scheduled Drug Products will be rejected. Please see example scenarios.

Example Scenarios	Claim Response	Action to Resolve
Claim submitted with a NPI where the associated DEA does not have authority for controlled Drug Products.	Claim will reject with Reject Code 46	Validate if Prescriber has an active DEA number. If found, verify and document the drug being dispensed is included within the prescriber's drug schedule. Then override with submission clarification code 46.
Claim submitted with a NPI where the associated DEA is inactive or expired for controlled Drug Products.	R43: Unauthorized DEA. Submit SCC 43	Validate if Prescriber has an active DEA number. If found, verify and document the drug being dispensed is included within the prescriber's drug schedule. Then override with a submission clarification code 43.
Claim submitted with NPI where the associate DEA not found.	Claim will reject with Reject Code: 44	Validate if Prescriber has an active DEA number. If found, verify and document the drug being dispensed is included within the prescriber's drug schedule. Then override with a submission clarification code 44.

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 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 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 not be a Clean Claim and will be rejected.

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.



The Administrator has not provided specifications for the American National Standards Institute (ANSI) 837 format, as the Administrator believes 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 are charts that provide valid codes for claims submission.

Patient Residence Code (PRC)	Patient Residence Code Description
00	Not Specified
01	Home
03	Nursing Facility/Long Term Care
04	Assisted Living Facility
06	Group Home
09	Intermediate Care / Mentally Retarded
11	Hospice

Pharmacy Service Type (PST)	Pharmacy Service Type Description
01	Community/Retail Pharmacy services
02	Compounding Pharmacy services
03	Home Infusion Therapy services
04	Institutional Pharmacy services
05	LTC Pharmacy services
06	Mail Order Pharmacy services
07	Managed Care Organization Pharmacy services
08	Specialty Care Pharmacy services
99	Other

OptumRx requires that all claims are submitted to the POS system with a Patient Residence Code (PRC – D.0 field 3844X) and Pharmacy Service Type (PST – D.0 field 147-U7). This is also a standard requirement of the NCPDP. Because both PRC and PST information is reported to CMS through the Prescription Drug Event (PDE), it is very important that accurate and appropriate information is submitted on every claim. 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.

If Network Pharmacy Provider is contracted for more than one service, please ensure claims are submitted with the appropriate PRC and PST codes for the services provided. For example, if Network Pharmacy Provider is contracted for providing Long Term Care pharmacy services, the appropriate PST is 05 (LTC Pharmacy services) and PRC 03 (Nursing Facility/Long Term Care). PRC 01 (Home) would not be an accurate code to use when providing Long Term Care pharmacy services.

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

U7 = Missing/Invalid Pharmacy Service Type
 4Y = Patient Residence Value Not Supported
 50 = Non-Matched Pharmacy Nbr

4X = Missing/Invalid Patient Residence
 4Z = Place of Service Not Supported By Plan

Examples of Common Combinations of Patient Residence Code (PRC) and Pharmacy Service Type (PST)

Where does the Patient reside or live?	What type of service is being provided to Patient?
Patient resides at Home – PRC 01	<p><i>Valid PST codes</i></p> <p>PST 01 – Pharmacy provides Community/Retail services PST 03 – Pharmacy provides Home Infusion Therapy services PST 07 – Pharmacy provides Managed Care Organization services PST 08 – Specialty Care Pharmacy services (must use POS = 99 when using PST = 08)</p>
Patient resides in Nursing Facility / Long Term Care – PRC 03	<p><i>Valid PST code</i></p> <p>PST 05 – Pharmacy provides Long Term Care services</p>
Patient resides in Assisted Living Facility – PRC 04	<p><i>Valid PST codes</i></p> <p>PST 01 – Pharmacy provides Community/Retail services PST 07 – Pharmacy provides Managed Care Organization services</p>
Patient resides in Group Home – PRC 06	<p><i>Valid PST codes</i></p> <p>PST 01 – Pharmacy provides Community/Retail services PST 07 – Pharmacy provides Managed Care Organization services</p>
Patient resides in Intermediate Care/Mentally Retarded Facility – PRC 09	<p><i>Valid PST code</i></p> <p>PST 05 – Pharmacy provides Long Term Care services</p>
Patient resides in Hospice – PRC 11	<p><i>Valid PST code</i></p> <p>PST 01 – Pharmacy provides Community/Retail services</p>

Nebulizing Solutions for Medicare Members

Nebulizing or inhalation solutions administered in a nebulizer for Members residing in long term care (LTC) are determined to be a Medicare Part D benefit, otherwise these products are determined to be a Medicare Part B benefit. OptumRx has configured products to pay under the appropriate benefit based on a Member’s benefit coverage and PRC submitted on the claim. However, pharmacies may still see rejections for Part D Non-Formulary products, or to direct the claim to the Part B benefit for Members who do not have Part B coverage under the specific prescription benefits for which the claim was submitted. Please follow rejected claim messaging to determine next steps to resolve the rejected claim. Verify that the PRC submitted on the claim accurately reflects where the Member resides. The following is a list of codes accepted by Medicare Part D plans:

Patient Residence Code (PRC)	Patient Residence
00	Not Specified
01	Home
03*	Nursing Facility
04	Assisted Living Facility
06	Group Home
09*	Intermediate Care Facility
11	Hospice

* Acceptable PRCs for a long-term care facility are “03” and “09” for all Medicare Part D plans.

If the PRC is correct, please verify that the appropriate Member ID card is being submitted for the benefit in which the nebulizing solution should be covered. If a Member changes Patient Residence Codes, the coverage and cost sharing of these drugs may change.

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)
- 5 = Pharmacy/Transfer

Claims submitted for a Prescription missing one (1) of these values will reject with the following: NCPDP Reject 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 Product Selection Indicated

- This is the field default value which is appropriately used for Prescriptions for single source brand, co-branded/co-licensed or generic Drug Products.
- For a multi-source Brand Name Drug with available Generic Drug(s), DAW 0 is not appropriate and may result in a reject.

DAW 1 — Substitution Not Allowed by Prescriber

- This value is used when the Prescriber indicates, in a manner specified by prevailing law, that the product is medically necessary to be dispensed as written. DAW 1 is based on Prescriber instruction and not Drug Product classification.
- Network Pharmacy Providers must document "DAW 1" on the original Prescription specifying the Prescriber's request to dispense the Brand Name Drug.

DAW 2 — Substitution Allowed-Patient Requested Product Dispensed

- This value is used when the Prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the Member requests the Brand Name Drug.
- This situation can occur when the Prescriber writes the Prescription using either the Brand Name Drug or Generic Drug and the Drug Product is available from multiple sources.

DAW 3 — Substitution Allowed-Pharmacist Selected Product Dispensed

- This value is used when the Prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the Network Pharmacy Provider determines that the Brand Name Drug should be dispensed.
- This can occur when the Prescriber writes the Prescription using either the Brand Name Drug or Generic Drug and the Drug Product is available from multiple sources.

DAW 4 — Substitution Allowed-Generic Drug Not in Stock

- This value is used when the Prescriber has indicated, in a manner specified by prevailing law, that Generic Drug substitution is permitted and the Brand Name Drug is dispensed since a currently marketed Generic Drug is not stocked in the Pharmacy.
- This situation exists due to the buying habits of the Network Pharmacy Provider, not because of the unavailability of the Generic Drug in the marketplace.

DAW 5 — Substitution Allowed-Brand Drug Dispensed as a Generic

- This value is used when the Prescriber has indicated, in a manner specified by prevailing law, that Generic Drug substitution is permitted and the Network Pharmacy Provider is utilizing the Brand Name Drug as the Generic Drug entity.

DAW 6 — Override

- This value is used by various Claim processors in very specific instances as defined by the Claim processor and/or its Client(s).

DAW 7 — Substitution Not Allowed-Brand Drug Mandated by Law

- This value is used when the Prescriber has indicated, in a manner specified by prevailing law, that Generic Drug substitution is permitted but prevailing law or regulation prohibits the substitution of a Brand Name Drug even though Generic Drug versions of the Drug Product may be available in the marketplace.

DAW 8 — Substitution Allowed-Generic Drug Not Available in Marketplace

- This value is used when the Prescriber has indicated, in a manner specified by prevailing law, that Generic Drug substitution is permitted and the Brand Name Drug is dispensed since the Generic Drug is not currently manufactured, distributed, or is temporarily unavailable.

DAW 9 — Substitution Allowed by Prescriber but Plan Requests Brand. Patient's Plan Requested Brand Product to Be Dispensed.

- This value is used when the Prescriber has indicated, that Generic Drug substitution is permitted, but the Benefit Plan's formulary requests the Brand Name Drug to be dispensed.
- This situation can occur when the Prescriber writes the Prescription using either the Brand Name Drug or Generic Drug and the Drug Product is available from multiple sources.

- Medicaid program formulary rules require the brand product be dispensed. There are special considerations when applying this code for the Medicaid patients. Medicaid programs often place the multi-source brand product on the formulary and do not cover the generic alternative regardless of the prescriber's designation of substitution allowed. Pharmacy should follow the instructions below when processing claims in this scenario.
 1. For the initial fill, pharmacies are likely unaware of Medicaid formulary details and that the branded product is required. The pharmacy would likely dispense the generic equivalent and submit a claim for the generic equivalent with DAW Code 0 (No Product Selection Indicated).
 2. Since the Medicaid program has identified the brand product as the preferred drug, the claim submitted with DAW Code 0 may be rejected with Reject Code (511-FB) 606 (Brand Drug/Specific Labeler Code Required). Additional information will be supplied in the Response Claim Segment regarding the preferred product in the Preferred Product ID (553-AR).
 3. Upon receiving Reject Code 606, the pharmacy shall resubmit the claim with the preferred brand drug and DAW Code 9 (Substitution Allowed by Prescriber but Plan Requests Brand).



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 require or will adjudicate with 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:

- Check for a diagnosis on the prescription or contact the prescriber if no diagnosis is listed.
 - The Administrator has notified Prescribers of this diagnosis match requirement.
- Then verify all diagnosis information submitted via the POS System and document verification in your system.
 - This information is subject to audit.
- Enter the ICD-10 code by including the clinical segment (NCPDP segment 13) on the submitted Claim.
 - 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



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.
3. COB Other Coverage Code (OCC) Details – The following COB OCC codes are allowed:
 - 0 – Not Specified; Submit when Member does not specify other coverage.
 - 1 – No Other Coverage; This code is used when no other coverage is available.
 - 2 – Other Coverage Exists; Payment Approved. OCC 2 is used when any positive amount of money is approved from another payer. Submit the amount approved from the primary payer.
 - 3 – Other Coverage Exists; Claim Rejected. OCC 3 is used when the beneficiary has other coverage, and the claim was rejected as not covered.
 - 4 – Other Coverage Exists; No Payment Approved. OCC 4 is used when a patient’s other coverage is active and there was no payment amount approved from the other insurer (i.e., the beneficiary has not met their deductible obligation, the total cost of the claim is less than the patient’s cost share requirement).
 - 8 – Claim Billing for Patient Financial Responsibility Only (allowed on select benefits only)
 - Per the NCPDP, it is recommended that each of the component pieces of the patient pay be submitted with their applicable qualifier OR, if the itemized components do not sum to the patient pay amount, then submit with the qualifier value of “06” (Other Payer-Patient Responsibility Amount Qualifier (351-NP)), with the appropriate total Patient Pay Amount (505-F5), as reported by previous payer, instead of submitting each component.



It is prudent for the Network Pharmacy Provider to verify with Members to ensure they do not have alternative primary or secondary insurers. Please 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, PDP or IFP.

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:

- OptumRx List 1 RxBINs: professionals.optumrx.com > Resources > Payer sheets
- OptumRx List 2 RxBINs: professionals.optumrx.com > Resources > Payer sheets
- OptumRx List 3 RxBINs: For the Payer Sheets, click [here](#).

Continuity of Care

When applicable and in accordance with particular laws and requirements, Network Pharmacy Provider will provide continued care to Members in exchange for the respective Prescription Drug Compensation amounts described in the Pharmacy Network Agreement.

Interpreter Services

To the extent applicable as determined by Administrator or Client, all in-network pharmacies are required to provide language interpreter services based on the state's requirements and/or regulations.

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 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. Evidence of unsafe compounding practices may be reported to the State Board of Pharmacy, Food and Drug Administration (FDA) or applicable regulatory agency.

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 Usual and Customary (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 Average Wholesale Price (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 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.
- For each ingredient in which Network Pharmacy Provider uses tablets or capsules in a compounded medication, (weight/weight compounds in which the weight of the tablet displaces the weight of the final product not applicable to other compounds such as weight/volume), Pharmacy must document the total weight of the tablets or capsules prior to adding them to the compound.
- Compounds containing Medicare Part B ingredients should be submitted to a Part B carrier.

Note: Reconstituted preparations (e.g., powdered antibiotics mixed with water prior to dispensing) are not considered Compounded Drugs.

- 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 D.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, or the exception process 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 partner with a third-party vendor to assist in the Compounded Drug credentialing process. Network Pharmacy Provider will be required to meet all 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.

Code Compounded Drug Description		Examples of Compounded Drugs
11	Compounded Drug do NOT contain an Active Pharmaceutical Bulk Powder Ingredient or Excipient	Magic Mouthwash, combinations of manufactured dermatological creams/ointments
12	Compounded Drug CONTAINING at least 1 Active Pharmaceutical Bulk Powder Ingredient	Simple suspensions, dermatological preparations
13	Compounded Drug requiring pH adjustment for stability, use of liposomal bases, troches, rapid dissolve tablets, suppositories, capsules (any route of administration)	Lansoprazole suspensions, omeprazole suspensions, pain creams in liposomal bases, troches, rapid dissolve tablets, suppositories, capsules (oral, nasal, etc.)
14	Compounded Drug CONTAINING Hazardous/Controlled	Compounded Drug hormone (any dosage form), topical pain creams containing controlled substances, chemotherapy

15	Sterile Compounded Drug - must be compounded in a <797> compliant environment and are dispensed as sterile finished preparation	Any sterile Compounded Drug
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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 an FDA-registered wholesaler with distribution locations within the United States and point of origin from an 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.
- Medically- accepted indication not only refers to the indication but also the route of administration of the compound.

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

- Applies 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 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 on the approved Claim 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
- Pharmacies cannot collect the Part B cost share when a Member is enrolled in an MAPD plan AND has qualifying Medicaid coverage.
- Refusing to dispense a Covered Prescription Service, including Compounded Drugs, 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.
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 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. 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. This dispensing fee is subject to change by the State or by Administrator in the absence of State requirements and may differ by the State or 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. This fee is subject to change by Administrator.

Processing a Compounded Drug Claims with Non-covered Ingredients

In the event a non-covered ingredient (such as bulk powders, invalid NDC's, plan exclusions, etc.) 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. Vaccine and Immunization Administration

Commercial, Medicare Part B and IFP

When your pharmacy administers vaccines listed in the annual flu season communication for eligible 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 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 Professional Service Code of Medication Administration (MA).

Vaccine Day Supply Submissions – Pharmacies should submit vaccines with a 1-day supply to align with the

NCPDP recommendation and to ensure appropriate cost-sharing is applied to the vaccine claim.



To participate in Administrator Vaccine and Immunization programs, please contact your Optum Rx Contract Manager or email independent.contracting@optum.com.

Coronavirus (COVID-19) Vaccine Billing

At this time, the cost for the COVID-19 vaccine is covered by the federal government via funding authorized by the Coronavirus Aid, Relief and Economic Security (CARES) Act and publicly available to all members, regardless of coverage type, with \$0 cost-share (copayment, coinsurance, or deductible). Providers may submit claims for the payment of the administration of COVID-19 vaccines to insurers and for exempt, and uninsured patients to the HRSA Provider Relied Fund.

Claims may be processed through a medical or pharmacy benefit at a client's discretion. Claims for Medicaid members will have coverage based on State Medicaid specific guidance. Plans that have chosen not to cover the COVID-19 vaccine under the pharmacy benefit and have chosen to cover through the member's medical benefit will contain claim messaging indicating the reason for the rejection.

For Medicare members, the Centers for Medicare & Medicaid Services has mandated a \$0 cost share, including members who are dual eligible for both Medicare and Medicaid, through Medicare Part B, and have advised that all providers should submit directly to Fee for Service (FFS) Medicare through 2021. As such, COVID-19 Vaccine administration claims with fill dates prior to 2022 for Medicare Plans will reject A5 and contain messaging to submit the claim to Original Medicare FFS

The standard OptumRx pharmacy benefit setup submission details are described below.

When your pharmacy submits a claim for either a multi-dose or a single-dose COVID-19 vaccine for administration fee reimbursement, the following NCPDP fields depicted below should be included and follow recommended guidance.

	NCPDP Field Number	First Dose	Second Dose (If Applicable)	Additional Doses (If Applicable)	Booster Dose (If Applicable)
Professional Service Code	440-E5	MA	MA	MA	MA
DUR/PPS Code Counter	473-7E	1	1	1	1
Day Supply	405-D5	1 - Day	1 - Day	1 - Day	1 - Day
Submission Clarification Code (SCC)	420-DK	02 (Applicable for single-dose and two-dose vaccines)	06 (Applicable for single-dose and two-dose vaccines)	07 (Applicable for two-dose vaccines)	10 (Applicable for single-dose and two-dose vaccines)
Ingredient Cost Submitted	409-D9	\$0.00 (\$0.01 if system requires)	\$0.00 (\$0.01 if system requires)	\$0.00 (\$0.01 if system requires)	\$0.00 (\$0.01 if system requires)
Dispensing Fee Submitted	412-DC	\$0.00	\$0.00	\$0.00	\$0.00

Basis of Cost Determination	423-DN	15 (Free Product)	15 (Free Product)	15 (Free Product)	15 (Free Product)
Incentive Amount Submitted	438-E3	Varies dependent on Federal, State and contractual guidelines.	Varies dependent on Federal, State and contractual guidelines	Varies dependent on Federal, State and contractual guidelines	Varies dependent on Federal, State and contractual guidelines
Product / Service ID / NDC	407-D7	EUA approved NDC	EUA approved NDC	EUA approved NDC	EUA approved NDC
Fill Number	403-D3	00	01	02	01/ 02 /03

To ensure claims process correctly, please enter and process the required values in the NCPDP Fields as outlined above in the above chart. Claims will not process accurately if the incorrect amount or code is entered and could result in a claim rejection or a Paid claim with a zero dollar administration fee.

E. 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 Network Pharmacy Provider’s (i) acknowledgment of its participation in the applicable network and (ii) 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. See Section III for contact information.

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 and reimbursement of Administrator's costs, including, but not limited to court costs, collection agents, travel and attorney's fees, reasonably incurred to recover the overpayment. If the Network Pharmacy Provider is disputing the reimbursement, please see MAC appeals contact information provided in Section III of this PM.

Payments

Administrator typically administers multiple payment cycles within compliance of federal and/or state regulations. Administrator reserves the right to make payment directly to a Network Pharmacy Provider at its sole discretion. 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 after the date of receipt for electronic Claims and within thirty (30) days after receipt for paper Claims.
- Unless a particular state Medicaid agency requires a shorter time period, Medicaid claims will be paid by Administrator within thirty (30) days of the Pharmacy's submission.

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 each Network Pharmacy Providers location for record-keeping purposes and Client Pharmacy Network directories.
- Effective January 1, 2016, and to the extent required by code 42 CFR § 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. thirty (30) 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 non-Clean Claim).

Interest on late Claims is calculated/ paid as stated by CMS and state regulations, as applicable. For further information, refer to your state's Clean Claim regulations or the current CMS guidelines.

Electronic Remittance Advice (ERA) 835 and Electronic Fund Transfer (EFT)

Network Pharmacy Providers have the option to participate in the ERA 835 and EFT. ERA provides improved analysis, reporting and a cost-effective alternative to the traditional "hard copy" or paper copy remittance advice. EFT provides improved timing of payments, payment tracking and a cost-effective alternative to the traditional "hard copy" or paper check.



Enrollment in EFT requires the Network Pharmacy Providers to be enrolled to receive an ERA. In the event of an ERA 835 reposted file which was issued without error and in a timely manner, the Network Pharmacy Provider will be charged \$75 per reposting transaction.

Once you are enrolled to receive an ERA or EFT, please see Pharmacy network contracting department contact information provided in Section III of this PM, if you have questions about a late or missing ERA or EFT. Network Pharmacy Providers that receive paper remittance may also contact OptumRx for claim detail when a negative balance is incurred.

The new EFT/ERA process is applicable for all OptumRx List 1 and List 2 RxBINs. Please note, the payment cycles and EFT/ERA files may differ by the respective BIN numbers. For additional information and enrollment instructions, access the OptumRx Healthcare Professionals website at professionals.optumrx.com.

Basis of Cost Determination Field

Effective May 26, 2021, to align with current NCPDP guidelines and State requirements, OptumRx requires pharmacies to submit a Basis of Cost Determination value of 15, indicating free product or no associated cost, when submitting an ingredient cost of \$0.00 or \$0.01.

- If the Basis of Cost Determination field (423-DN) is left blank or submitted with any code other than 15 when the ingredient cost of \$0.00 or \$0.01 is submitted, the claim will reject with code: DN – M/I Basis of Cost Determination.
- If a claim is submitted with Basis of Cost Determination of 15 and the submitted ingredient cost field (438-E3) is any amount other than \$0.00 or \$0.01, the claim will reject with code: 23- M/I Ingredient Cost Submitted.

Submitted Basis of Cost Determination (423-DN)	Submitted Ingredient Cost (438-E3)	Expected Result
15	\$0.00 or \$0.01	Claim will process
Left blank	\$0.00 or \$0.01	Claim will reject with code: DN – M/I Basis Cost Determination
Code is not 15	\$0.00 or \$0.01	Claim will reject with code: DN – M/I Basis Cost Determination
15	Any amount other than \$0.00 or \$0.01	Claim will reject with code: 23 – M/I Ingredient Cost Submitted

F. Member/Insured Appeal Rights

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

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.

1. A health care provider may initiate an appeal of a health carrier's or its agent's claim determination:
 - a. Within 90 calendar days of receipt of the health carrier's or agent's determination that is the basis of the appeal; or
 - b. Within 90 calendar days of a health carrier's or its agent's missed due date for the claim determination, including at the provider's option, a claim that has been pended.
2. A provider shall initiate an appeal by submitting to the health carrier or its agent a complete Claim Payment Appeal Form, which shall include all substantiating documentation required by the health carrier

or its agent. The carrier or its agent shall not reject an appeal based on the provider's failure to notify his or her patient of the appeal. The application form and instructions, which require the applicant to submit the name and contact information, the patient's name and the claim number with a description of the reason for appeal, are available for download on the Department's website at www.dobi.nj.gov. A health carrier or its agent may make available the application form and instructions on its website to allow for electronic submission of applications.

3. The health carrier or its agent shall conduct a review of the internal appeal and notify the health care provider of its determination within 30 calendar days of receipt of the application for internal appeal. The internal review shall be conducted by employees of the health carrier or its agent who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be provided at no cost to the provider. If the carrier or its agent fails to notify the provider of its determination within 30 calendar days of receipt of the application, the provider may initiate an arbitration proceeding in accordance with N.J.A.C. 11:22-1.13(c).
4. The health carrier or its agent shall communicate the results of the internal review in a written decision to the provider, which shall include:
 - a. The names, titles, and qualifying credentials of the person or persons participating in the internal review;
 - b. A statement of the provider's grievance;
 - c. The decision of the reviewer(s), together with a detailed explanation of the basis for such decision;
 - d. A description of the substantiating documentation, which supports the decision;
 - e. If the payment decision is adverse to the health care provider in any respect, a description of the method to obtain an external review of the decision by arbitration pursuant to N.J.A.C. 11:22-1.13; and
 - f. If the decision favors the health care provider in any respect, the health carrier or its agent shall be required to pay within 30 calendar days of the date of issuance of the health carrier's or its agent's determination of the internal appeal, the amount due as determined by in the internal appeal, if applicable, with accrued interest at the rate of 12 percent per year calculated from the date of receipt of the internal appeal by the health carrier or its agent at its designated address.

G. Utilization Management

Utilization Management Requirements

Some Covered Prescription drugs or products undergo a coverage review process including one or more of the following:

- **Prior Authorization (PA)** –Coverage programs such as Prior Authorization may be applied by Benefit Plan Sponsor to prevent coverage of select products that have potential for use that is typically outside the scope of the pharmacy or medical benefit (e.g., prescribed for treatment of conditions for which there is insufficient clinical evidence supporting safe and/or effective use); use for conditions which are not covered by the Plan (e.g., cosmetic use, or conditions excluded by the Plan); or use in situations where quantity or duration of treatment exceeds those defined as safe and effective in clinical compendia, treatment guidelines or supported through published and/or consulted expert opinion (e.g., Optum National P&T Committee). Products subject to PA may require confirmation of diagnosis or submission of laboratory results/chart notes and other supporting information.
- **Step therapy (ST)** – Step therapy promotes the use of one or more safe and cost-effective alternatives prior to authorizing coverage for the requested product. The recommended alternatives are considered preferred or first-line products with uses aligned to evidence-based practice as approved by the Optum National P&T Committee. The requested product is covered in situations where step therapy requirements have been met.
- **Quantity limits (QL)** – Provide coverage for quantities and/or duration of treatment that is supported by FDA approved product labeling. Quantity limits can be used to promote dose optimization (use of a higher

strength in place of two or more lower strength dosage units) to achieve the prescribed dose in order to simplify drug administration and lower plan costs. A Prior Authorization process exists in situations where members may require coverage for additional quantities of medication. The quantity limit review process can supplement existing PA or ST coverage reviews.

PA Review

A Member, Member's appointed/authorized representative and/or a Prescriber may submit a request to initiate the PA review process. If Prior Authorization of a Drug Product is required, the Network Pharmacy Provider must make good faith efforts to contact the Prescriber. 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 (P&T) Committee or other professionally recognized standards of practice. If a Member's Drug Product has a PA, ST or QL restriction, the Member or Member's appointed/authorized 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 mail or online at professionals.optumrx.com (using CoverMyMeds or Surescripts).

Prior Authorization (PA) Process Key Steps

- The Member's Prescriber or Member's appointed/authorized representative can submit a PA request.
- If the request and the provided information falls within established guidelines, the request will be approved.
- If the request and provided information 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 from the receipt of request to review the case or seventy-two (72) hours for Medicare Benefit Plans from receipt of request or prescriber's supporting statement if applicable.
- Urgent cases have a turnaround time of seventy-two (72) hours for commercial Benefit Plans, from receipt of request to review the case or twenty-four (24) hours for Medicare Benefit Plans from receipt of request or prescriber's supporting statement if applicable.
- Washington — For commercial fully insured and ASO non-ERISA Claims, if a Prior Authorization (PA) number is required to be transmitted on a Claim, Administrator will provide the authorization number to the Network Pharmacy Provider. The PA number will be communicated to Network Pharmacy Provider after approval of a PA request and or the authorized Covered Prescription Service.



Additional Information

Our PA department is staffed with licensed pharmacists, nurses, 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 approved by our national Pharmacy and Therapeutic (P&T) Committee. The Prescriber and Member or Member's appointed/ 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 76 or 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.

H. 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. Clinical edits can present as messages, Soft or Hard Rejects. 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 of Therapeutic Duplication (TD) requires the pharmacy 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 medication and compares them to the drug being processed. 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 research to determine 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 an override for 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, 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 code for each field.

Select the appropriate professional and Results Code from the following list.

OVERLAP:

Identifies claims where a Member is filling overlapping claims for specified drugs.

Medicare		
Reason for Service Code	Professional Service Code	Result of Service Code
TD (Therapeutic Duplication)	M0 (Prescriber Consulted)	1G (Filled, Prescriber Approval) 4B (Filled, Palliative Care) 4C (Filled, Hospice) 4D (Filled, Cancer Treatment) 4K (Pscbr Expt-Cancer/PalCare) 4L (Pscbr Exmpt-Hospice)
	MR (Medication Review)	4D (Filled, Cancer Treatment)
	R0 (Pharmacist Consulted Othr)	4B (Filled, Palliative Care) 4C (Filled, Hospice) 4D (Filled, Cancer Treatment) 4K (Pscbr Expt-Cancer/PalCare) 4L (Pscbr Exmpt-Hospice)
Commercial / Medicaid		
Reason for Service Code	Professional Service Code	Result of Service Code
TD (Therapeutic Duplication)	M0 (Prescriber Consulted)	1G (Filled, Prescriber Approval)
	R0 (Pharmacist Consulted Othr)	1B (Filled Prescription As Is)

Reason code High Dose (HD) returns in safety edits where the pharmacy system looks at the dosage of the active ingredients in the drug you are processing. It flags a Member's request to fill a medication if the ingredient's dosage exceeds the recommended amount in that prescription or combined with all prescriptions the Member is currently taking.

When the pharmacy system flags a medication for HD, it produces a Hard or Soft Reject. The following steps explain how to review and override the reject. Soft Rejects can be overridden at the Point-of-Sale (POS). Some Hard Rejects may be overridden if the Member meets the appropriate exemption criteria. Otherwise, a prior authorization is needed.

1. Consult with the Member's prescriber to confirm intent. The consultation should be consistent with current pharmacy practice to verify the prescription and to validate its clinical appropriateness. This is an opportunity for pharmacists to inform the prescriber of other opioid prescribers or increasing amounts of opioids.
2. Document the discussion and submit the appropriate override code. The documentation may include the date, time, name of prescriber and brief note that the prescriber confirmed intent, did not confirm intent, provided information on patient exclusion or could not be reached after (X) number of attempts.
3. If the prescriber confirms the dosage is medically necessary, then re-submit the claim with appropriate DUR/PPS Codes. Identify and enter the appropriate Reason, Professional, and Result Codes for each component that applies to the situation. Enter only one code for each field.

Select the appropriate professional and Results Code from the following list.

THERDOSE:

Assesses the total daily dose to include the single incoming claim along with overlapping claims in the Member's history based on specific ingredient. The edit will be triggered if the total daily dose exceeds the FDA-defined maximum daily dose.

Reason for Service Code	Professional Service Code	Result of Service Code
HD (High Dose Alert)	M0 (Prescriber Consulted)	1G (Filled,Prescriber Approvl) 1B (Filled Prescription As Is) 1C (Filled,Different Dose) 1D (Filled,Different Directns) 1F (Filled,Different Quantity) 1G (Filled,Prescriber Approvl) 2A (Prescription Not Filled) 3C (Discontinued Drug) 3D (Regimen Changed) 3E (Therapy Changed)
	P0 (Patient Consulted)	1A (Filled As Is,False Positv) 3K (Instructions Understood)
	R0 (Pharmacist Consulted Othr)	1A (Filled As Is,False Positv) 1B (Filled Prescription As Is) 1C (Filled,Different Dose) 1D (Filled,Different Directns) 1F (Filled,Different Quantity) 2A (Prescription Not Filled) 3C (Discontinued Drug) 3D (Regimen Changed) 3E (Therapy Changed)

The following information is around Commercial and Medicaid Plans. Information around Medicare Opioid Guidance can be found in the link: <https://professionals.optumrx.com/resources/manuals-guides/medicare-opioid.html>.

DDI-DTMS:

- Drug-Drug Interaction (DDI); Drug Therapy Monitoring System (DTMS) Screening: Reject Code 88
- Assess Member's prescription history to detect possible adverse interactions between submitted drug and others being taken by the Member.
- 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.

Reason for Service Code	Professional Service Code	Result of Service Code
DD (Drug-Drug Interaction)	M0 (Prescriber Consulted)	1G (Filled,Prescriber Approvl)
	R0 (Pharmacist Consulted Othr)	1B (Filled Prescription As Is)

MEDLIMIT:

Assess for cumulative dose of opioid that exceed a daily morphine equivalent dose threshold. The daily limit is referred to as the Morphine Milligram Equivalent (MME) limit. Depending on the plan, there may be multiple MME limits with varying response levels (Soft or Hard Reject).

Reason for Service Code	Professional Service Code	Result of Service Code
HD (High Dose Alert)	M0 (Prescriber Consulted)	1G (Filled,Prescriber Approvl)
	R0 (Pharmacist Consulted Othr)	1B (Filled Prescription As Is)

I. Retrospective Intervention Program and Other Clinical Programs

Retrospective Intervention 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:

Care Gap Management

The Care Gap Management program drives quality of care by closing Drug Product gaps for Members with select chronic diseases. Using evidence-based medicine, the program identifies and intervenes on Members who are not on recommended therapies for their disease states (e.g. asthma, diabetes and cardiovascular disease). The program also incorporates quality measures supported by CMS, Healthcare Effectiveness Data and Information Set (HEDIS), and Pharmacy Quality Alliance (PQA).

Medication Safety Management

The Medication Safety Management program identifies and intervenes on Members with potential Drug Product safety concerns targeting areas including drug-drug interactions, drug-disease interactions, therapeutic duplication and drug-age.

Stars Quality Management

The Stars Quality Management program provides comprehensive alerts developed for Medicare plans to align with CMS Star Rating programs to promote quality driven alerts that include CMS Star Measures, display measures, and safety measures using pharmacy and medical claims.

Medical Insights Management

The Medical Insights Management program intervenes on Members with medication safety concerns and gaps in medication therapy, using insights from both medical and prescription claims.

Opioid Risk Management Program

OptumRx Opioid Risk Management is a program to improve the quality of patient care by reducing potentially inappropriate usage of opioids. OptumRx program includes prevention and education along with adjudication edits designed to minimize early exposure (limitations to initial therapy) and reducing inappropriate supply (edits to prevent an excess beyond standards of care).

Medicare Part D Drug Management Program

The Drug Management Program (DMP) identifies Members who are using high doses of opioids that are prescribed by multiple prescribers and/or filled at multiple pharmacies and those that have had a recent opioid related overdose. These Members are potentially at risk for abuse or misuse of opioids and their case will be reviewed by an assigned clinical pharmacist. If needed, the pharmacist will outreach to the prescribers to verify medical necessity of the current opioid usage or obtain agreement to place the Member in a medication management plan to help them better manage their opioid usage. This plan can take the form of various restrictive edits ranging from drug level restrictions to prescriber and pharmacy lock-ins. Members will receive two notifications if they will be placed on a medication management plan. The first letter will be sent at least 30 days before the restriction starts. A second letter will be sent on the day that the restriction starts. DMP is a CMS compliance and safety program and complies with all standards and requirements as set forth by CMS in their official published guidance documents. It also is the successor to older iterations of similar programs such as Level 3 and Opioid Overutilization Program.

Meds on Track

Adherence is defined as the measure of how well a member follows a specific regimen of taking a drug product as prescribed by a healthcare professional. Members who are adherent to their medications have a lower likelihood of hospitalization, emergency room visits and condition-specific healthcare costs compared to Members who are not adherent. The OptumRx® Medication Adherence program uses a data-driven approach to identify Members who need help taking medications as prescribed across multiple drug classes — including those to treat diabetes, hypertension, high cholesterol, HIV/AIDS, mental health, as well as respiratory conditions. The program offers a continuum of care and full service capabilities. It uses machine learning and artificial intelligence to target higher risk Members, monitors behaviors for improved adherence, offers expert consultations and engages individuals in an optimal way, based on their preferences and preferred channel of communications. Targeted outreach includes:

- **New to Therapy Letter:** This is a welcome letter sent to Members when they are prescribed a new medication they have never taken before, to provide education on the most common indications for the medication and a few helpful tips on best adherence practices.
- **Primary Medication Non-Adherence:** Multichannel outreach is used to send providers mailings and faxes, alerting them of Members who did not start their new therapy, and provide guidance for next steps for the prescriber to make to the member for support and assistance.
- **Refill Reminders:** Interactive IVR reminding Members to refill their medications, typically two (2) days after late to fill with a 10 day follow up as needed. Members have option to be transferred to their last dispensing pharmacy to refill.
- **Low adherence:** these program alerts go out when a member's adherence to their targeted medication falls below 80% PDC (proportion of days covered) as measured by claims history in the last 6 months
 - Educational letters to Members about the importance of being adherent with tips on how to remember to take their medication.
 - Multichannel outreach, sending providers mailings and faxes alerting them of Member non-adherence; including the relevant prescription history
 - Interactive IVR with barrier survey and tips to address barriers to following their medication regimens. This also offers Members the option to connect with a live OptumRx pharmacist for phone consultations. The IVR collects barrier information which will be reported back to the client on a quarterly and/or monthly basis.
- **Predictive Non-adherence:** Encouragement messages via IVR outreach to Members with highest risk of becoming non-adherent with their medication regimen. Member risk is determined by machine learning predictive analytics reviewing over 100 member demographic data points. The IVR outreach also includes an option for the member to connect with a live OptumRx pharmacist for a consultation on adherence.

Diabetes Management Program

The OptumRx diabetes program is designed to help Members control blood sugar, A1c levels, disease progression and comorbidities. The OptumRx Diabetes Management program provides targeted guidance and services designed to prevent costly and clinically dangerous complications. The program consists of fully integrated management strategies that bring together data, insight and clinical skills from a broad range of sources, including pharmacy, medical, ancillary care, and lab results. Using machine learning and artificial intelligence, Member risk levels are identified to tailor outreach and support.

- All members with diabetes are offered basic diabetes education to improve their understanding of the disease. We monitor these Members daily and intervene at crucial points in their care to help them stay adherent to their medications.
- High-risk Members are offered more comprehensive and personalized care, connecting them with certified diabetes educators for more hands-on clinical expertise and support.

Orphan Drug Program

The Orphan Drug Program focuses on Members taking orphan drugs who have the greatest opportunity for a clinical intervention to achieve better outcomes and total cost of care savings through drug discontinuations (i.e., when the medication has no benefit and is likely to be causing harm) and dose optimizations when clinically

appropriate. One-on-one coaching is performed by OptumRx clinical pharmacists that are specially trained and have clinical expertise in managing orphan medications and the conditions for which they treat. Each OptumRx clinical pharmacist will also communicate with providers to ensure all gaps in care are closed and that there are no major drug-related safety concerns that will cause negative outcomes for Members.

- Members receive a comprehensive medication review, which includes an in-depth review of their currently prescribed medication and validates that the member is taking the orphan drug for the correct indication and that the benefits of taking the orphan drugs outweighs the risks.
- The pharmacist and member collaboratively establish a detailed medication action plan that identifies therapy goals and timelines.
- Members receive additional follow-up consult sessions for the rest of the program year.

Over 350 proprietary rules focused on orphan drugs deliver personalized alerts for clinical concerns and medication contraindications such as maximum daily dose, drug-drug and drug-disease interactions and non-adherence. These data driven interventions help optimize dosing, confirm drug safety and effectiveness, and determine whether an orphan drug should be discontinued and/or alternative options should be used.

Cost Management Program

The Cost Management program 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 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.

J. 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 help manage market pricing fluctuations on the MAC list. Administrator's MAC lists are also regularly reviewed at least every seven (7) calendar days 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 appeal 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 Appeal form ("MAC Form") to Administrator within thirty (30) calendar days from the date of service submitted on the Claim, as well as adhere to state-specific requirements. For pharmacies that are contracted with a PSAO, MAC appeals must be submitted to the PSAO for processing or in accordance with applicable state law. The use of the PSAO will allow for coordinated tracking of requests and responses.

Administrator shall investigate and resolve the appeal within thirty (30) business days after the fully completed form is received. All MAC appeal review determinations on any individual claim from a pharmacy are final and will not be reviewed again. 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.

MAC appeal 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 may be required to submit their actual acquisition cost (including any rebates) for each item being reviewed. Unless specifically required, 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.

Please access the MAC Appeal Submission Guide for instructions on processing appeals at the following link: [MAC appeal submission guide \(optumrx.com\)](https://www.optumrx.com/mac-appeal-submission-guide).

MAC State-Specific

To the extent your Network Pharmacy Provider is located in a state requiring different time periods to submit or resolve MAC Appeals than noted above, please see the Appendix F.

Administrator reviews appeals in accordance with state laws as applicable, which can vary based by line of business (e.g. Commercial, Medicare, Medicaid, etc.). In addition, if your pharmacy is located in one of the states listed in the Appendix F, the respective state provision(s) in Appendix F supplements or replaces that aspect of the OptumRx standard MAC Appeal process.

In addition to MAC Appeals, Administrator does not prohibit Pharmacies from filing complaints with regulators for any and all other applicable issues, including the Department of Insurance. However, the Network Pharmacy Provider should first follow the Dispute Resolution Process described in the Pharmacy Network Agreement.

K. 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.

L. Transmission fees

Notwithstanding anything to the contrary in this Manual or the Agreement, transmission fees which may vary in amount will be incurred, subject to applicable regulatory requirements, 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 non-compliance 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.

M. Pharmaceutical manufacturers' cost- share amount coupons

Network Pharmacy Provider is responsible for ensuring pharmaceutical manufacturer copayment cards or coupons (i.e. "coupons") are not utilized for Claims under the Medicare Part D, other federally-funded health programs, and any commercial or Medicaid Client Benefit Plan[s] that prohibits use of coupons to offset all or a portion of a Member's Cost- Sharing Amount.

Network Pharmacy Providers must include operational practices to require validation of each customer/Member that presents a copayment card coupon to assure that use of a coupon is not prohibited by the health program and/or Benefit Plan. Network Pharmacy Providers accepting coupons in lieu of collecting the full cost-share amount in violation of the health program and/or Benefit Plan may be subject to audit, recovery and other administrative actions, up to and including termination from all Administrator's Pharmacy Networks.

N. Tax on Covered Prescription Services

Certain state or local jurisdictions may impose a tax on Covered Prescription Services. This tax obligation shall apply to, and be payable by, the Network Pharmacy Provider unless the law expressly requires the Administrator or its health plan client reimburse or pay the tax on behalf of the Network Pharmacy Provider. In the event the law applies the tax on the Administrator or its health plan client, and the Network Pharmacy Provider timely seeks reimbursement that includes that tax, the Network Pharmacy Provider must enter the accurate tax amount in the appropriate field on the Claim submission.

O. Disputed claims

In the event a Network Pharmacy Provider seeks to dispute a Claim due to alleged error, miscalculation, discrepancy or non-compliance 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.



Questions can be submitted on the Pharmacy Provider Relations Intake Form: [Pharmacy Provider Relations Intake Form \(optumrx.com\)](#)

P. 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.

Dispensing Limitations

Any claim submitted to Administrator exceeding Benefit Plan limitation for the days supply or quantity billed 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) days supply) and rejects as stated, the Network Pharmacy Provider must request an override through the Pharmacy Help Desk and resubmit the Claim utilizing the appropriate quantity and the accurate days supply.

If an override is not available and the Network Pharmacy Provider is not able to submit a claim for the accurate days supply, the Network Pharmacy Provider must document what the actual days supply is for the claim in the system, and calculate refill intervals based on the actual days supply and not the submitted days supply to prevent early refills and potential waste.

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 (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 Prescriber.

Documentation of such directions must be on the original prescription and the prescription label.

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 prescribed directions and quantity billed. Audits routinely identify discrepancies in days supply errors. Treatment therapy should be included in determination of days supply, including any off-days of the therapy. The following are examples of appropriate days supply submission:

- One (1) patch weekly is four (4) patches for a twenty-eight (28) days supply.
- Two (2) tablets twice weekly is sixteen (16) tablets for a twenty-eight (28) days supply.
- One (1) tablet daily for three (3) weeks on, one (1) week off is twenty-one (21) tablets for a twenty-eight (28) days supply.
- A thirty (30) days supply is no longer standard; some programs permit extended days supplies. Always transmit the accurate day's supply and allow the on-line system to communicate the allowable days supply.
- Vaccines should be submitted with a quantity that corresponds to the unit of measure and not the package size. The days supply submitted for all vaccines should be 1-day supply.

Quantity

Network Pharmacy Providers must enter a quantity dispensed that is consistent with the prescribed directions for use and billed days supply. 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, and an override is not available, it is allowable to resubmit with the communicated days supply which represents the plan maximum.
- 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) days 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 CFR § 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.

Q. 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 (e.g. Qualified Medicare Beneficiary or other Qualifying Medicaid coverage) 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.

In accordance with U.S. Department of Health & Human Service, Health Resource Services Administration ("HRSA") rules and requirements, Network Pharmacy Providers owned by or contracted with a 340B Participating Entity may discount or waive the Cost-Sharing Amounts owed by Members for reasons of genuine financial need.

In these situations, CMS rules and the Agreement allow 340B Participating Pharmacies to do the following:

- After submitting the claims for Part D Covered Prescription Services for Medicare Part D Members via the POS System, 340B Participating Pharmacies may adjust, discount or waive the Cost-Sharing Amount provided by the on-line POS System response per the guidance on genuine financial need as described by HRSA.

R. 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 within fourteen (14) calendar days from original submission must be reversed.

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).

S. 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 NDC for a repackaged drug or (ii) Claims for Covered Prescription Services filled using drugs imported or reimported into the United States (U.S.).

T. 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.

U. 340B 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 340B 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 340B program. Failure of Network Pharmacy Provider to notify Administrator of its 340B eligibility as stated above shall constitute a material breach of the Agreement.

V. 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).

W. Dispensing Physicians

Dispensing physician's office should be limited to dispensing medications within the scope of their practice,

dispensing must be limited to prescribers' own patients and there is no delivery or mailing of the medications. Patients must have the option to fill the prescription at a pharmacy of choice. Procedural requirements such as record keeping, copayment collection, medication labeling, storage requirements, purchasing, security and personal supervision will be the same as a retail pharmacy.

X. Medication Synchronization

Medication Synchronization allows Members to refill all of their Prescriptions on the same day, eliminating the need for multiple trips to the Pharmacy each month. Prescriptions are filled for less than the normal prescribed day supply in order to align the refill date across multiple prescriptions, allowing all refills on the same day and time period.

State requirements vary on the Drug Products which can be included in the synchronization, as well as the types of plans which must comply with the regulations.

Effective October 15, 2020, Network Pharmacy Providers may use Submission Clarification Codes (SCC) 61 or 48 to override the **Refill Too Soon** (RTS) Reject (i.e. Code 79) and/or **DUR/DUPRX** Reject (i.e. Code 88) on Drug Products which qualify for synchronization.

- SCC 61 – Synchronization Fill - Shortened Days Supply: Used to request an override for shortened days supply to allow the synchronization of dates of service across multiple medications, so all prescriptions can be refilled at the same time.
- SCC 47 – Other - Shortened Days' Supply Fill: Only used to request an override to plan limitations when a shortened day supply is being dispensed when a distinct value for the business case has not been defined.
- SCC 48 — Fill Subsequent to a Shortened Days Supply Fill: Used to request an override to plan limitations when a fill subsequent to a shortened days' supply is dispensed.

Only Drug Products qualifying for synchronization and plans which have set-up this functionality will process using the SCC 48 and 61 codes. Exclusions may include Drug Products for acute therapy, unbreakable packages and controlled substances.

Y. Submission of the Pharmacy's Cash Price as the U&C Price

Network Pharmacy Providers are required to submit all Claims via the POS System to Claims Processor for the cash price charged Members for all Covered Prescription Services dispensed to Members as the Usual & Customary (U&C) price and to collect the applicable Cost-Sharing Amounts. The U&C, or cash, price is the amount charged 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, price matching, coupons or other discounts, a cash paying customer pays Network Pharmacy Provider for Drug Products, devices, products and/or supplies, including those which are offered by Network Pharmacy Providers without cost (e.g. a U&C of \$0 should be submitted).

Z. Contraceptive Services Only (CSO)

The Affordable Care Act (ACA) generally requires all non-evergreen health plans and health insurance issuers to cover certain preventive health services without cost-sharing when rendered in-network. This requirement includes a \$0 cost share coverage of at least one form of birth control in each of the FDA-approved female contraceptive methods shown in the Contraception section of the latest HRSA-supported Women's Preventive Services (not all of which are relevant to a pharmacy benefit).

However, exemptions and accommodations are available to "Employer Class Members" (as defined in a June 5, 2019 permanent nationwide [injunction](#)) that object to providing the mandated contraceptive coverage based on

sincerely held religious or moral beliefs.

<p>For an Employer Class Member who claims the religious or moral exemption, neither the employer nor the issuer/TPA provides coverage for some or all contraceptives to which the employer objects.</p>	<p>For an Employer Class Member who claims the now-optional accommodation for some or all contraceptives, the objectionable coverage is: (a) excluded under the employer’s standard benefit; and (b) covered under a separate CSO benefit by the issuer/TPA who agrees to contract with that employer. The employer must either: (a) provide the required notice of its religious objection to the issuer/TPA via this EBSA Form 700; or (b) notify HHS of its objection via this Model Notice to Secretary of HHS – HHS would then have to authorize the issuer/TPA to provide a separate CSO benefit to the employer’s Members. The employer does not contract, arrange, pay, or refer for the separate CSO benefit.</p>
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- Members that have this CSO benefit, will have a CSO ID card, which contains the CSO carrier ID of EXMORX and BIN/PCN/Group: 610011/IRX/EXMORX. Contraceptives not covered under the CSO formulary will reject with code 70.
- A Member has the right to appeal a denial for a contraceptive prescribed for birth control purposes through the OptumRx standard appeal process. Under a plan subject to the ACA’s EHB requirements, a Member has the right to request an exception review for coverage of clinically appropriate non-formulary contraceptives.

VI. BIN Information



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 2/1/2019 and is subject to change at any time. Please see Pharmacy help desk service contact information provided in Section III of this PM.

A. OptumRx List 1: Prescription Bank Identification Numbers (RxBINs)

010876	610094	016580	860917	610613
600428	610084	610127	610097	610094
610279	610494	112233	016580	017366
017472				

OptumRx List 1 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 professionals.optumrx.com > Resources > Payer sheets.

B. OptumRx List 2: Prescription Bank Identification Numbers (RxBINs)

001553	003452	003650	004469	610704
005757	005947	006524	007887	008878
009117	009951	010553	011149	011297
011321	011677	011792	011867	012163
012295	012502	012882	012924	013170
013907	014582	014681	014872	015383
015558	015756	015764	015789	015814
015962	016093	016143	017010	017911
018240	018643	600428	600471	601577
601683	603017	603286	610011	610014
610106	610118	610140	610170	610171
610182	610212	610527	610548	610550
610560	610593	610619	610621	610622
610623	610648	610652	610675	800010
610679				

OptumRx List 2 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

010876 For additional payer-specific required data elements for the above RxBINs, please refer to the applicable legacy Payer Specifications via professionals.optumrx.com > Resources > Payer sheets.

For Administrator D.0 Payer sheets Related to Medicare Part D, Commercial and Medicaid, click [here](#).

C. OptumRx List 3: Prescription Bank Identification Numbers (RxBINs)

Please see OptumRx List 3: Prescription bank identification numbers (RxBINs) provided in the Workers' compensation and auto no-fault section of this PM.

D. OptumRx Guide: Assists in Identifying the Appropriate BIN/PCN to Submit Claims

This is not a comprehensive list of BIN/PCN combinations and may change at any time. Please check the Member's ID card.

Client name	BIN	PCN
AARP MedicareComplete Essential (HMO); AARP MedicareComplete Choice Essential (PPO); AARP MedicareComplete Plus Essential (HMO- POS);	610494	9999
AARP MedicareRx Plans insured through UnitedHealthcare: AARP MedicareRx Preferred PDP; AARP MedicareRx Saver Plus PDP; AARP Welfare Plan	610097	9999
Acclaim (MME)	601683	*
Advocate Health Care	610494	9999
American Health Care	014872; 018240; 610118	*
Appalachian Regional Healthcare Systems	610127	01960000
Arizona Health Care Cost Containment System (AHCCCS)	001553	AZM
Atlantic Prescription Services	610704	*
Avia	610550	*
Blue Cross Blue Shield of Arizona	603017	*
CalPERS	610097	9999
Calvos	003650	64
Capital District YMCA	610011	NMHC
CareOregon	610011	CORMCARE; IRX
City of Milwaukee	610097	9999
Community and State (C&S) MMP of Ohio - Medicaid	610494	9999

Community and State (C&S) MMP of Ohio - Medicare	610097	8500
COMMUNITY HEALTH	610613	2417
Department of Veterans Affairs	610593	VA
Equian	010553	ALS; HT
FLEXSCRIPTS	017472	FLEXRX
Florida Health Care	610593	SXC; SXCFLH
Florida Share of Cost	610494	2222
Fred's Inc.	610011	FREDSIRX
GARDA	610011	NMHC
General Electric (GE) Care Clinics	610494	9999; Grp: GECRX
Health Alliance Plan of Michigan	610011	HAPAHL; HAPCOMM; HAPMEDD; HAPQAOFF; HAPQCOFF; HAPQHP1ON; HAPQHP4ON
Healthcare Solutions Inc.	010876	*
Helios/Tmesys processing with Envoy	002538	Envoy account number
IBC - Independence Blue Cross	015814	06080000; 06090000; 06430000; 06440000
	610011	CTRXMEDD
LDI Integrated Pharmacy Service	800010	*
Innoviant Commercial	610127	02330000; COSF; GASF; MASF; NCCSI; NCSF; NWSF; OHSF; SCCSI; SCSF
Various Clients	017366; 017472; 610084; 610127; 610613	*
	610097	*; 8500
	610494	*; 2222; 9999
Restat Client	011149; 016093; 600471; 610171	*
Maryland Medicaid	610084	RXSOLPRD

MaxCare Rx (PPOK)	610170	*
MedalistRx	016580	*
Medliance LLC	610593	BEI; MDL; MDLCOB; NC; OCRMDLPDMMDL
Milwaukee County	610097	9999
Client name	Bin	PCN
MPSERS	610011	CTRXMEDD
Multiple Clients	003650	Varies
Nevada Medicaid - HPES	001553	NVM
Nugget Markets	610011	NMHC
NYC Transit Authority	610127	02330000
Ohio Bureau of Workers Compensation	610593	OHBWC
OmedaRx	610212	*; 02300000; 02310000; 02320000; 02330000
OmedaRx	610622	*; 02070000; 03000000; 03010000
OmedaRx	610623	*; 02100000; 02110000; 02120000
OmedaRx	610648	*

Other	003452; 004469; 005757; 006524; 007887; 009117; 011297; 011321; 011677; 011792; 011867; 012163; 012295; 012502; 012924; 013907; 014582; 014681; 015383; 015558; 015764; 015789; 016143; 603286; 610014; 610140; 610182; 610560; 610619; 610652; 610675; 610679	*
	005947	*; CLAIMCR
	610011	IRX
	610097	9999
	610127	01960000; 02330000
	610494	5555; 9999
	610527	*; VL
	610593	*; SXC
Oxford	610279	9999
PartnersRx Coupons	610494	3333
PBM Plus, Inc.	610106	*
Pennsylvania Public School Employees' Retirement System	610097	9999
Pharmastar, LLC.	610593	PRSMEDD
Physicians Health Choice Basic (HMO); Physicians Health Choice Select (HMO SNP)	610494	9999
Preferred Care Partners/The Villages	610097;	9999
	610494	9999
Presbyterian	610593	PHPCC
ProAct	017366	9999
Publix Super Markets Inc	005947	CLAIMCR; PUBLIX

Raytheon COB	610127	04000001; 04000002; 04000004
Rx Relief	015756	RELIEF; RXRELIEF
	017911	*
ScripNet	610621	*
SeniorScript	013170	*
SERV-U	610548	*
Sierra Medical Advantage Prescription Drug MAPD – Health Plan of Nevada	610097	9999
Simply Healthcare	015789	SIMPLY
SRPS (aka Helios)	005567	TPS
SRPS previously Third Party Solutions/TPS (aka Helios)	005567	TPS
State Health Plan of North Carolina (SHPNC)	610097	9999
State of Arkansas	601577	0038
State of Georgia Medicaid	001553	GAM
State of Indiana Medicaid	001553	INM
Steuben Area Schools	610527	VL
TeamStar Medicare Part D	610097	9999
Tennessee Health Management	610127	01960000
Transit Employees Health and Welfare Plan	610097	9999
Trust Plus	009951	*
TMESYS - (aka Helios); Helios formerly PMSI (aka Helios);	004261	CAL
U.S. Federal Claims	004261	FED
U.S. Postal Service	004261	USP
U.S. Virgin Islands Senior Citizens Affairs Pharmaceutical	610097	9999
UFCW	003650	64
UFCW of New Mexico	601577	0038
Union Pacific Railroad Employees Health Systems	610011	UE7316; NMHC; UPREHS
UnitedHealthcare	610279	*; 9999

UnitedHealthcare Insurance Company: Maryland (POS, EPO, PPO); UnitedHealthcare of the Mid-Atlantic: Maryland (HMO); MAMSI Life and Health Insurance Company: Maryland (EPO, POS); Optimum Choice, Inc.: Maryland (HMO)	610279	9999
UnitedHealthcare Employer and Individual – Contraceptive Services Only	610279	CONTRAC
UnitedHealthcare Medicare Complete (HMO) in New Jersey	610097	8500
UnitedHealthcare Community Plan of: Kansas; Louisiana; Michigan; Texas; UnitedHealthcare Community Plan Coordination of Long-Term Services (CoLTS); UnitedHealthcare Medicare Complete Essential (HMO); UnitedHealthcare MedicareDirect Essential (PFFS); Non-Part D Plans (MA and Retiree Drug Subsidy [RDS] only); UnitedHealthcare	610494	9999
"UnitedHealthcare Connected for MyCare Ohio (Medicare-Medicaid Plan)"	610097	8500
UnitedHealthcare Dual Complete (DH, DH-POS, DP, RDP);	610097	9999;
UnitedHealthcare Dual Complete (HMO SNP) including, but not limited to, New York; Michigan; Wisconsin; Tennessee; UnitedHealthcare Nursing Home Plan (IH, IH- POS, IP); UnitedHealthcare Senior Care Options in Arizona	610097	9999
UnitedHealthcare Medicaid Supplemental Plan	610494	2222
UnitedHealthcare MedicareRx for Group PDP	610097	9999;
UnitedHealthcare Senior Care Options in Massachusetts	610097	8500
Walgreen Company	018643	PRACTIVES; WAGACTIVES
Welldyne	008878; 015962	*
World Trade Center	004261	WTC
Zenith, CA only	004261	ZEN
UnitedHealthcare Community Plan of Arizona	610494	4100
UnitedHealthcare Community Plan of California	610494	4444
UnitedHealthcare Community Plan of Florida	610494	4300
UnitedHealthcare Community Plan of Hawaii	610494	4500
UnitedHealthcare Community Plan of Kansas	610494	9999
UnitedHealthcare Community Plan of Massachusetts	610494	9999
UnitedHealthcare Community Plan of Maryland	610494	RXSOLPRD
UnitedHealthcare Community Plan of Michigan	610494	4242
UnitedHealthcare Community Plan of Mississippi (CAN)	610494	4646
UnitedHealthcare Community Plan of Mississippi (CHIP)	610494	4747

UnitedHealthcare Community Plan of Nebraska	610494	4444
UnitedHealthcare Community Plan of New York	610494	4800
UnitedHealthcare Community Plan of Pennsylvania	610494	4200
UnitedHealthcare Community Plan of Rhode Island	610494	4201
UnitedHealthcare Community Plan of Texas	610494	4400
UnitedHealthcare Community Plan of Virginia	610494	4900
UnitedHealthcare Community Plan of Washington	610494	4600
UnitedHealthcare Community Plan of New Jersey	610494	4343
UnitedHealthcare Individual and Family Plan	610279	7777

VII. 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 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; even if used for non-cosmetic purpose (i.e. morbid obesity).
 - Examples: Meridia, Phentermine
- Agents when used to promote fertility.
 - Examples: Clomiphene Citrate, Follistim, Gonal-F
- Agents when used for cosmetic purposes or hair growth.
 - Examples: Botox Cosmetic, 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
- Covered 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 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 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
- Under MA-PD Benefit Plan 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.

Coverage determination is required when Members with a MA-PD use insulin administered in a pump. When submitting an insulin Claim for a Medicare Advantage Member, you will receive the following message: "Part B if pump, call 1-800-711-4555." To ensure Claims are paid under the correct benefit, please notify the Prescriber and Medicare Advantage Member the review is required to determine coverage when insulin is administered in a pump.

Insulin administered in a pump:

Claims for Medicare Advantage Members, who use a pump to administer their insulin, should pay under the Medicare Part B benefit. Please see Prior authorization (PA) service contact information provided in Section II of this PM and ask Prescriber to initiate a coverage determination. The Medicare Advantage Member may also initiate a coverage determination by calling the customer service number on the back of the Member ID card.

Insulin self-administered without a pump:

Medicare Advantage Members who do not use a pump to administer their insulin do not need to request a coverage determination. Their Claim will automatically pay appropriately under their Medicare Part D benefit. 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). Value "51" – Not paid under Part D paid under Part C benefit (for MA-PD plan). Beneficiary is a Qualified Medicare Beneficiary - pharmacy should not attempt to collect cost-share, but instead should attempt to bill COB to Medicaid coverage.
- 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 (393MV) 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 non-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 Products 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 appointed/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, Member's appointed/authorized representative, Prescriber or other authorized Prescriber may appeal the decision by calling the Customer Service number listed on his or her Member ID card or may follow the 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 Reject Code 619 — Prescriber Type 1 NPI Required, or 56 — "NPI EXISTS. PRESCRIBER ID INVALID/NOT ALLOWED" and the corresponding NPI number may 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 & 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. Submit all Claims; Claims Adjustments

Network Pharmacy Providers shall at all times submit Part D Covered Prescription Services to Medicare Drug Plan Members via the POS System to Claims Processor and furnish Part D Covered Prescription Drugs in a manner that permits the Part D Sponsor to comply with Medicare laws and regulations. Failure to submit all Part D Covered Prescription Services may impact Part D Sponsor's STAR ratings as well as individual Medicare Drug Plan Member's benefit calculations. 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.
- In the Medicare Prescription Drug Benefit Manual, Chapter 14, CMS has acknowledged the use of free or discounted drug programs and indicated claims must be submitted by Network Pharmacy Providers to allow for accurate reporting of Medicare Drug Plan and Member paid amounts. Please review section Submission of Pharmacy's Cash Price as the U&C Price within this Provider Manual for additional information. Please ensure that claims for \$0 prescription drug costs are submitted, unless the Member specifically requests that the claim not be processed using his/her prescription drug benefit.

As permitted by the Centers for Medicare & Medicaid Services (CMS), Network Pharmacy Provider does not collect Member Cost-Sharing due to the presumption of Medicaid entitlement due to institutional status of the Member. Network Pharmacy Provider certifies that as a condition for reimbursement from Administrator for claims in which the Medicare Part D Cost-Sharing has been reduced or waived:

- Long Term care (LTC) is defined as patient residence codes 03-Nursing Facility/LTC and 09-Intermediate Care facility/Mentally Disabled ONLY.
- Network Pharmacy Provider has not and will not collect Cost-Sharing Amounts from the Member (or any

other party who paid on the Member's behalf); or Network Pharmacy Provider has otherwise waived the same Cost Sharing Amounts for the Member (or any other party who paid on the Member's behalf);

- In the event that the Network Pharmacy Provider did collect a cost sharing amount from the Member and also received reimbursement from OptumRx (ORx), the Network Pharmacy Provider is expected to reimburse the Member or their representative within 45 days of receiving refund.
- Network Pharmacy Provider is in fact carrying a debt for the amounts incorrectly charged to Members;
- The amounts reimbursed are appropriate, owed and payable in accordance with applicable federal and state requirements.
- Network Pharmacy Provider shall retain the appropriate documentation/records to establish these certifications, including for purposes of an audit.

H. Coverage Limitations

A Drug Product is considered eligible for payment under Medicare Part D if it is used for a medically accepted indication. Per the Medicare regulations and implementing guidance, medically accepted indication is defined as any use of a covered Part D drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the uses of which is supported by one or more citations included or approved for inclusion in any of the compendia described in Section 1972(g)(1)(B)(i) of the Act. The recognized compendia are:

- American Hospital Formulary Service-Drug Information (AHFS-DI)
- DRUGDEX Information System

For cancer uses, this definition includes prescribed uses supported by a citation included or approved for inclusion in one (1) of the following compendia or resources:

- American Hospital Formulary Service-Drug Information (AHFS-DI)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- DRUGDEX Information System
- Clinical Pharmacology
- Lexi-Drugs
- One of the CMS approved peer reviewed literature sources

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. Refill percentages are subject to members plan benefits.

I. Medication Therapy Management (MTM)

Consistent with the Medicare Modernization Act (MMA) requirements for MTM, the Benefit Plan provides MTM 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.

MTM Eligibility

CMS requires that MTM 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 \$4,935 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 MTM.

Our Medication Therapy Management Program (MTMP) is focused on improving therapeutic outcomes for Medicare Part D members. To qualify for MTMP, a member must meet all of the following criteria:

1. Members must have filled eight or more chronic Part D medications; and
2. Member must have three (3) chronic diseases The following are examples of chronic diseases:
 - a. High Blood Pressure
 - b. High Cholesterol
 - c. Congestive Heart Failure (CHF)
 - d. Diabetes
 - e. Depression
 - f. Osteoporosis
 - g. Rheumatoid Arthritis
 - h. Asthma
 - i. COPD
 - j. HIV
3. Members must be likely to incur annual costs of \$4,935 for all covered chronic Part D medications. OR
4. Are in a Drug Management Program to help better manage and safely use medications such as opioids and benzodiazepines.

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

Scope of MTM Services

The scope of the MTM services is determined by each Medicare Part D Benefit Plan. In selecting MTM 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 MTM 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 or qualified provider.
- Providing an individualized written summary with action plan and recommendations.
- Performing quarterly targeted Drug Product reviews on an ongoing basis.

MTM 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 MTM program or any of its components. Administrator reviews the available medical and pharmacy Claims data on a daily basis to determine MTM eligibility. In the absence of medical Claims data, a Drug Product proxy tool may be used for verification of diagnosis.

MTM Reimbursement for Network Pharmacy Providers

As of the date of the publication of this PM, Administrator is solely responsible for designing, developing and implementing MTM related clinical services on behalf of its Clients and Benefit Plan Sponsors. Network Pharmacy Providers are reimbursed for completion of case work through the OptumRx® MedMonitor portal.

MedMonitor Care Management Platform

The Optum Rx MedMonitor clinical platform enables an end-to-end approach for community pharmacists to conduct reimbursable interventions for Medication Therapy Management and other clinical consults with identified

members.

Designed by and for pharmacists, MedMonitor:

- makes it quick and easy to review medications and offer wellness support to your patients – in person or over the phone
- drives additional revenue opportunities to your location, through medication therapy management CMRs as well as a suite of additional evidence-based, reimbursable interventions you can complete
- provides structured workflows, personalized clinical content and automated CMR fulfillment and prescriber communications, reducing the administrative burden associated with each clinical intervention

Learn more and get signed up for MedMonitor today to take advantage of the clinical revenue opportunities that support your patient's healthcare and your business.

How do I get started on the MedMonitor portal?

To access the MedMonitor portal:

1. Visit the Optum Rx MedMonitor portal at <https://medmonitor.optumrx.com>.
2. Click Create a One Healthcare ID and complete all entries, including name as it appears on your pharmacy license
3. After successfully creating the ID, sign in again using your ID.
4. Register for a pharmacy location and enter the NCPDP/NABP or NPI number then click "Validate" (If multiple NCPDPs need to be added, you can request that through the help desk later on.)
5. Please select the appropriate role from the dropdown options to sign up for this portal then select "Validate details" and the registration will be sent for approval.
6. Check the MedMonitor portal daily to weekly to complete clinical interventions and get your reimbursements!

How do I get additional support?

We offer training materials and a training guide. We can also provide you a demo of the system where you can ask questions. Work with your pharmacy contact to get a demo set up with the MedMonitor team. If you have other issues, you call or email the MedMonitor Help Desk on Monday – Friday from 8:00 am - 4:00 pm CST at (866) 840-1923 or email medmonitor@optum.com.

J. Medicare Part D Transition Policy

Under certain circumstances, we are required to cover a temporary supply of a drug that is not on the Benefit Plan's Formulary or is subject to Benefit Plan requirements or restrictions to avoid a gap in therapy.

The Member may be eligible to receive a temporary transition supply of the Drug Product. A transition fill is allowed for at least thirty (30) days or plan's month supply (whichever is greater) at any time during the first ninety (90) days of Membership for new Members or the first ninety (90) days of the calendar year for existing Members unless the Prescription is for an unbreakable package. If the prescription is for an unbreakable package, please refer to the Unbreakable Packages section. The prescription may be filled at a network pharmacy.

The Medicare Part D Sponsor provides notice to its Members and their Prescriber(s) 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 may receive a point-of-sale claims messaging of a temporary transition fill. 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 at least thirty (30) days or plan's month supply (whichever is greater), 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. The plan may also allow 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 at least thirty (30) days or plan's month supply (whichever is greater, 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. Contact the OptumRx pharmacy helpdesk for a level-of-care transition supply override if the Member is being discharged with the prescribed Drug Product.

K. Medicare Part D Transitioning LTC Facility Residents

If the Member is a resident of an LTC facility, the Medicare Part D Sponsor will also cover a temporary transition supply. A transition fill is allowed for at least thirty-one (31) days or the plan's month supply (whichever is greater) at any time during the first ninety (90) days of Membership in the Member's Medicare Part D Plan unless the Prescription is for an unbreakable package. If the Prescription is for an unbreakable package, please refer to the Unbreakable Packages section.

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 at least thirty-one (31) days or plan's month supply (whichever is greater) unless the Prescription was written for fewer days or the Prescription is for an unbreakable package. If the Prescription is for an unbreakable package, please refer to the Unbreakable Packages section. The plan may also allow 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 or you as their pharmacy may request a level-of-care transition supply of at least thirty-one (31) days or plan's month supply (whichever is greater) (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. Contact the OptumRx pharmacy helpdesk for a level of-care transition supply override if the Member is being discharged with the prescribed Drug Product.

L. Unbreakable Packages

Drug Products in "unbreakable packages" must be dispensed in their original container/package and cannot be opened or broken. Please submit these Claims with a day supply consistent with the dosing instructions on the Prescription.

Claims for Drug Products in unbreakable packages:

- Will not be rejected if the days' supply exceeds contractual plan limitations.

- May be rejected if the submitted days' supply is inconsistent for dosing instructions.

If a Claim may be submitted with fewer packages or a smaller package size, the Claim may reject with “7X – Day’s Supply > Plan Limitation.” The Claim messaging will advise of next steps to process the Claim:

1. Use the smallest package size (the Claim can be filled using a smaller unbreakable package).
 - Please resubmit Claim using this Drug Product in a smaller package size.
2. Submit fewer unbreakable packages.
 - Please adjust the quantity or days supply to accurately account for dosing instructions.

For Medicare Part D: Transition eligible Drug Products in unbreakable packages can be dispensed in excess of the limitations described in Sections "Medicare Part D Transition Policy" and "Medicare Part D Transitioning LTC facility residents". If the Member is eligible for a full or partial transition supply, messaging may state “For CMS Transition, resubmit with remaining day supply of [#] or less.” Resubmit the Claim with the smallest package size or fewest unbreakable packages that provides at least the transition day supply remaining.

M. 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.

N. 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
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Valid Submission Clarification Code and Special Packaging Indicator Combinations

NCPDP field name	NCPDP field ID (SCC2)	Appropriate value for SCD claims	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.

O. Daily Cost Share (DCS)

Network Pharmacy Providers will be responsible for costs associated with erroneously submitted Claims. Incorrect and erroneously submitted Claims are non-Clean Claims.

In response to CMS requirement pursuant to 42 CFR section 423.153(b)(4)(i), Medicare Part D Sponsors must apply a DCS rate when certain Prescriptions are dispensed by a Network Pharmacy Provider for less than a one (1) month 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 Members for trial fills for less than one (1) month supply.
- Facilitate synchronization of Prescriptions through reduced Cost-Sharing.
- Reduce instances of unused Covered Prescription Services.

DCS requirement applies to the first fills/refill sync and any fill of less than one (1) month, unless the Drug Product

is exempt for any of the following:

- 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 Members with compliance.

The following submitted clarification codes may be used to override 'Refill Too Soon' rejections to synchronize fills related to DCS:

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

P. Medicare Part D Thirty (30) Day Negative Formulary Change Notice

Notice of Negative Formulary changes will be available online and disseminated periodically through Faxblast Communication to Network Pharmacy Providers thirty (30) 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 thirty (30) days before it takes effect.

Q. 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 may be eligible to a transition fill. See section for Medicare Part D Transition Policy.

R. 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.

S. 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 Member's appointed/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 Member's appointed/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 Member's appointed/ authorized representative demonstrates consent.

Network Pharmacy Providers are required to maintain documentation showing the Member or Member's appointed/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.

Be aware that when dispensing Part B covered drugs or supplies to Medicare Advantage Plan Members who have Full Medicaid, also known as Traditional Medicaid (including SLMB+), but where the Member is not located in the same state as the Pharmacy, that the Part B copay cannot be collected from the Member if they have qualifying Medicaid coverage for the service. This is the case even if the Pharmacy cannot or is not contracted with the Member's residing state Medicaid.

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 Member's appointed/ 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 Member's appointed/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.

T. Medicare Part B Cost Sharing for Dual Eligibles/Prohibition of Balance Billing

Medicare Advantage Plans - also known as MAPD or Part C - are Medicare approved insurance plans administered by private companies. They take the place of and combine original Medicare benefits Parts A (hospital), B (medical), and D (prescription drug). Dual Eligibles are Medicare beneficiaries who are also eligible for some level of Medicaid assistance. Most State Medicaid programs have a legal obligation to pay Medicare cost-sharing (deductible, copay or coinsurance) for these individuals.

Balance billing is the practice in which Medicare Providers seek to bill a QMB (Qualified Medicare Beneficiary) for Medicare cost-sharing (also known as a copay). As a reminder, CMS strictly prohibits contracted Medicare Physicians, Network Pharmacy Providers, including those servicing beneficiaries enrolled in a Medicare Advantage Plan (i.e. MAO, MAPD/Part C or Managed Care), from balance billing these Members. When the beneficiary has QMB, the Medicare cost-share must be submitted to Medicaid and the reimbursement amount accepted as payment in full - even if the approved amount is \$0.00. If Medicaid imposes a Medicaid copay after processing the Medicare cost share, the pharmacy may collect this amount from the Member. Inability to submit a claim (whether it is systemic or because the Network Pharmacy Provider is not contracted with Medicaid) – is not a valid reason to collect the Medicare cost-share amount from the beneficiary. Some Medicaid programs do not allow electronic secondary billing when the claim is processed through the Medicare Advantage Plan. An electronic rejection usually means another billing method is required like a paper claim or submission through a Medicaid billing portal. Contact Medicaid to determine how to appropriately bill the Medicare cost-share amount when the Member is enrolled in a Medicare Advantage Plan and has QMB. Network Pharmacy Providers who bill QMB Members for any remaining Medicare cost-share balance may be penalized (as established in Section 1902(n)(3)(C) of the Social Security Act) and/or terminated from the pharmacy network.

Most Medicaid agencies will cover all or a portion of the Medicare cost-share for Full Medicaid individuals as well,

even if they do not have QMB. The pharmacy should verify and coordinate Medicaid benefits appropriately. OptumRx requires that Network Pharmacy Providers bill Medicaid for Members who have any qualifying Medicaid coverage for the Medicare cost-share.

Reference document with CMS Language: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf>

U. Medicaid Dual Status Codes and Medicare Cost Share Coverage

- CMS 01 Partial Dual – QMB only (Qualified Medicare Beneficiary): Must bill Medicaid for Medicare copay – no exceptions. CMS strictly prohibits Balance Billing.
- CMS 02 Full Dual – QMB+ (Qualified Medicare Beneficiary plus Full Medicaid): Must bill Medicaid for Medicare copay – no exceptions. CMS strictly prohibits Balance Billing.
- CMS 03 Partial Dual – SLMB only (Specified Low Income Medicare Beneficiary): Medicare copay not covered by Medicaid; copay is Member responsibility.
- CMS 04 Full Dual – SLMB+ (Specified Low Income Medicare Beneficiary plus Full Medicaid): Conditional – Verify Medicaid DME benefits and bill Medicaid for the Medicare copay when covered.
- CMS 05 Partial Dual – QDWI (Qualified Disabled and Working Individuals): Medicare copay not covered by Medicaid; copay is Member responsibility.
- CMS 06 Partial Dual – QI (Qualified Individual): Medicare copay not covered by Medicaid; copay is Member responsibility.
- CMS 08 Full Dual – Full Medicaid Benefit Dual Eligible: Conditional—Verify Medicaid DME benefits and bill Medicaid for the Medicare copay when covered.

COB/TPL Handbook: <https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf>

Note: refer to Chapter 2, section E, #3 for Types of Dual Eligibility and #4 for the Medicaid Coverage for Medicare Costs chart

As a reminder, network providers shall comply with all state and federal laws and regulations.

V. Claim Notification – Dual Eligible Members and Part B Drugs

OptumRx allows some Medicare Part B covered drugs or diabetic supplies to be submitted to the claims processing system under the Medicare Part D BIN/PCN. This will allow the pharmacy to identify Medicare Part B claims and Dual Eligible Members who have coverage for the Medicare Part B copay.

- Benefit Stage Qualifier field (BSQ) will be populated with value 51 on the pricing segment response (D.0 Field #393-MV) when a UnitedHealthcare Medicare Advantage Member receives a Medicare Part B covered service and the Centers for Medicare & Medicaid Services (CMS) has notified the plan that QMB (Qualified Medicare Beneficiary) or Full Medicaid coverage exists.
 - When BSQ value 51 is present, the pharmacy must refrain from collecting the copay from the Member - otherwise known as “Balance Billing.”
 - An additional alert may be provided via local claims messaging stating CMS Medicaid Status Code and Partial or Full Dual status (see chart on above): “Part B claim; If BSQ=51, bill Medicaid for copay. Balance Billing prohibited.”
- If a Member indicates they have QMB or Full Medicaid coverage, but BSQ value is not 51, the pharmacy should contact the Member’s State Medicaid or the number on the back of the Member’s UnitedHealthcare ID card to verify status.
- The pharmacy should bill Medicaid for the remaining Medicare Part B copay or balance. If Medicaid imposes a Medicaid copay after they process the Medicare Part B secondary claim, the pharmacy may collect this amount from the Member.
- Medicaid is always the payer of last resort and should never be billed as primary to circumvent coordination of benefits with the Medicare Advantage Plan.

W. 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.

X. Medicare Notice of Patient's 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 10146) 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.

Y. Compliance

Compliance Plan

All Medicare Advantage Organizations (MAO), Medicare Part D Sponsors, Medicare-Medicaid Plans (MMPs) and Medicaid Managed Care Organizations (MCO) are required to have a compliance plan which meets regulatory requirements (42 CFR Parts 422 and 423). It must be reasonably designed, implemented and enforced to be effective in preventing, as well as detecting non-compliance with regulatory requirements. This includes program-specific (e.g. Medicare Part D) requirements, as well as preventing/detecting potential criminal/fraudulent conduct. Administrator has a compliance plan in place which aligns with Federal Sentencing Guidelines and supports the monitoring/detection of FWA (fraud, waste and abuse) within federal programs.

Administrator, as well as our Client MAOs, Medicare Part D Sponsors, MMP and Medicaid MCO's, have compliance plans that are built around and include the elements below:

- Written policies and procedures:** Standards of conduct to assist employees, independent contractors and agents complying with applicable laws, including Medicare and Medicaid requirements.
- Compliance officer/compliance committee:** Designation of a compliance officer and compliance committee.
- Education and training:** Education and training programs to ensure understanding of compliance requirements, including but not limited to, HIPAA standards, and ethical/compliance expectations. In addition, the Network Pharmacy Provider must have a system to train employees, whether developed and provided by the Network Pharmacy Provider or provided by a validated and reputable vendor (HIPAA, standards of conduct and ethical/compliance expectations, etc.) Network Pharmacy Provider's employees must, at minimum, receive training within 90 days of initial hiring and annually thereafter.
- Effective lines of communication:** A process to report violations of the standard of conduct without fear of retaliation.
- Monitoring and auditing:** A system to monitor and audit activities within the Network Pharmacy Provider

for compliance with applicable laws. In addition, the Network Pharmacy Provider must have a system to monitor whether employees, independent contractors and agents have been sanctioned by the Medicare or Medicaid Programs. Network Pharmacy Provider 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.

- i. OIG: <https://www.oig.hhs.gov/exclusions/index.asp>
- ii. GSA: <https://sam.gov/SAM>
- iii. Contact applicable State Medicaid Agency websites for exclusion information

Network Pharmacy Providers should be aware that Administrator and/or Benefit Plan Sponsors shall not pay for drugs prescribed by a health care provider or provided by a Network Pharmacy Provider excluded by the Office of Inspector General's (OIG) - U.S. Department of Health & Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE), General Services Administration (GSA) – System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS), state Medicaid exclusion lists or any other regulatory authority that has an exclusion list pursuant to 42 CFR §1001.1901.

- F. **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.
- G. **Responding to detected offenses and developing corrective action initiatives:** A system to investigate allegations of noncompliant behavior by employees, independent contractors, or agents.

In addition, Network Pharmacy Provider should initiate an investigation immediately, but no more than two (2) weeks from the date a potential compliance or fraud matter has been reported or identified. If, upon investigation, the Network Pharmacy Provider believes a potential misconduct has occurred, the Network Pharmacy Provider is required to report the alleged activity to the Administrator without fear of retaliation. Administrator has a strict non-retaliation policy which protects those reporting any adverse action as a result of a good faith report.

Reports should be submitted to the administrator at:

- Pharmacy Programs – (800) 613-3591 or via email pharmacyprograms@optum.com
- Customer service number identified on the back of a Member's ID card

In addition, the Network Pharmacy Provider may also report this information to the following:

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
- 1-877-7SAFERX (1-877-772-3379)

Network Pharmacy Providers are expected to support applicable compliance program activities.

Pharmacy Marketing Activity

CMS has issued instruction, included in the Medicare Communications and Marketing Guidelines (MCMG) Manual, on provider marketing activities. CMS is concerned providers' (which includes Network Pharmacy Providers) with 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. As such, Network Pharmacy Provider may not specifically market to any Benefit Plan.

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, 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 a consultation area.

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.

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 Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials in common areas when provided to the Network Pharmacy Provider.
- 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 www.cms.gov or 1-800-MEDICARE (1-800-633-4227)
- 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 complaints 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.

Z. 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 or Hard Rejects, depending on the Member's plan, when a Member exceeds the acetaminophen maximum daily dose and returns messaging only for several other therapeutic categories. Administrator may 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 where clinically appropriate to expedite successful adjudication of THERDOSE rejections (e.g. DUR Reject Code 76 or 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 Code 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 Prescriber 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
M0	Prescriber Consulted	1A	Filled As Is, False Positiv
M0	Prescriber Consulted	1B	Filled Prescription As Is
M0	Prescriber Consulted	1C	Filled, Different Dose
M0	Prescriber Consulted	1D	Filled, Different Directions
M0	Prescriber Consulted	1F	Filled, Different Quantity
M0	Prescriber Consulted	2A	Prescription Not Filled
M0	Prescriber Consulted	3C	Discontinued Drug
M0	Prescriber Consulted	3D	Regimen Changed
M0	Prescriber Consulted	3E	Therapy Changed
P0	Patient Consulted	1A	Filled As Is, False Positiv
P0	Patient Consulted	3K	Instructions Understood
R0	Pharmacist Consulted Othr	1A	Filled As Is, False Positiv
R0	Pharmacist Consulted Othr	1B	Filled Prescription As Is
R0	Pharmacist Consulted Othr	1C	Filled, Different Dose
R0	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 two 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.

AA. DUR Medicare Part D Morphine Milligram Equivalent (MME) Limits Edits

The Administrator Morphine Milligram Equivalent Limits (MMELIMIT) screening within the concurrent DUR program applies edits which minimize the risk of Prescription overutilization. The rules monitor for cumulative total daily opioid Prescriptions used above the plan's established daily MME limit across multiple Claims. Currently the Administrator standard includes Soft or Hard Rejects when a Member exceeds the plan's established daily MME limit. The MME value is calculated based on the number of opioid Drug Products prescribed over a period of time which includes incoming Claims and Claim history. Opioid ingredient conversion factors used in the POS MME calculations are approved for use by the Centers for Medicare & Medicaid Services (CMS) and are taken from publications by the Centers for Disease Control and Prevention (CDC) at <http://cdc.gov>. For plans which allow Soft Rejects, Pharmacies can override the Soft Reject where clinically appropriate to expedite successful adjudication of MMELIMIT rejections (e.g. DUR Reject Code 88) at POS.

BB. Medicare Advantage Benefit Plans (MA)

For claims submitted for Medicare Part B Covered Prescription Services for the respective Benefit Plan Sponsor's MA or MA-PD Benefit Plans, Network Pharmacy Provider shall refer to the POS System response for the applicable Benefit Plan as payment in full. The POS System transaction response pricing per Claim prevails, unless overpayment is made to the Network Pharmacy Provider.

CC. Medicare-D Drug Management Program Member Pharmacy Lock-In Edit

The Medicare Part D Drug Management Program focuses on appropriate use of Member opioids and frequently abused medications and now allows pharmacy lock-in edits per CMS as part of a medication management plan for patient safety and better coordination of care between providers. Network Pharmacy Providers that are contracted with Administrator will participate in the pharmacy lock-in component of the Drug Management Program (DMP), which applies to the Network Pharmacy.

The Administrator reserves the right to add, delete, or modify the policies associated with the lock-in program. Network Pharmacy Providers shall be deemed participating in all components associated with the Drug Management Program pharmacy lock-in limitation and may not terminate or refuse participation. The Administrator will notify Network Pharmacy Providers when a Member will be locked in for coverage of their opioid and frequently abused medications in writing before the edit takes effect. Pharmacies that are not in-network but have been selected to be the designated pharmacy in a lock-in will receive notification in writing and will need to send back a response form confirming acceptance of the Member pharmacy lock-in edit.

A prescriber lock-in can be implemented under more than one prescriber, (i.e. two prescribers within the same practice or one prescriber for opioids and one prescriber for benzodiazepines). However, the Administrator cannot

implement a prescriber lock-in without obtaining an agreement from the prescriber(s) first during the course of case management. Prescribers will be notified of their Member's prescriber lock-in via receiving a copy of the Member Initial Notice, which will contain a cover letter addressed to the prescriber to provide a summary of the case management decision and directing them to review the copy of the letter sent to the Member.

VIII. Compliance; Fraud, Waste and Abuse (FWA); General Training; Audits



A. Network Pharmacy Provider FWA; and General Compliance Training

A Network Pharmacy Provider is required to report any suspected or potential FWA to the Administrator. Administrator has a strict non-retaliation policy which protects those reporting any adverse action as a result of a good faith report. Administrator actively investigates and refers, as appropriate, any FWA activity by Network Pharmacy Providers, associates, Members, vendors, contractors and/or other business entities.

Network Pharmacy Provider should initiate an investigation immediately, but no more than two (2) weeks from the date a potential compliance or fraud matter has been reported or identified. If, upon investigation, the Network Pharmacy Provider believes a potential misconduct has occurred, the Network Pharmacy Provider is required to report the alleged activity to the Administrator without fear of retaliation.



Reports should be submitted to the Administrator at:

- Pharmacy Programs – (800) 613-3591 or via email pharmacyprograms@optum.com
- Customer Service number identified on the back of a Member's ID card

In addition, the Network Pharmacy Provider may also report this information to the following:

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
- 1-877-7SAFERX (1-877-772-3379)

A Network Pharmacy Provider involved in providing services for Medicare Part D/Medicaid Members is responsible for implementing a program to control FWA and to facilitate compliance in the delivery of Covered Prescription Services through the Medicare/Medicaid benefits.



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

In addition to the reporting requirements above, 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).

Common FWA Schemes to Avoid

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



The following is a list of FWA types 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. Some examples of an illegal remuneration scheme include when a Prescriber receives something of value for writing Prescriptions for medically inappropriate or unnecessary drugs/products or to induce the Prescriber to prescribe certain Drug Products rather than others, when a Network Pharmacy Provider waives a Member's Cost-Sharing Amount to encourage their patronage, etc.
- **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.
- **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 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 federal health care programs for the samples.



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

- **Overutilization and drug-seeking Members:** Member seeks, obtains and uses a Drug Product even though the risk of harm exceeds the benefit.
- **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.
- **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 as Drug Products 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:** Member misrepresents personal information, such as identity, eligibility or medical condition in order to illegally receive benefits including Medicare and Medicaid.
- **Theft of prescriber identifiers:** Member steals 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 dispensing a Generic Drug
- Billing for an NDC other than what was dispensed
- Overbilling of quantity prescribed
- Billing multiple payers for the same Prescription
- Inappropriate billing of Compounded Drugs
- Submitting a dummy DEA/NPI or Invalid DEA/NPI number 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 of Drug Products supplied in unbreakable packages 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 limit, 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
- Phantom Claim billing: Claims for Covered Prescription Services not provided

- Dispensing expired or adulterated Prescription Drug Products
- Forging or altering Prescriptions
- Refilling Prescriptions erroneously
- TrOOP manipulation

Cultural Competency with Abuse, Neglect and Exploitation Training

Network Pharmacy Providers are to be knowledgeable about cultural differences of our Members, so as to promote the delivery of services in a manner which accounts for the diverse Member population which is completely free of bias including, but not limited to, those with limited English proficiency, diverse cultural/ethnic backgrounds and mental and physical disabilities.

Additionally, providers must cultivate an environment free from discrimination based on gender, sexual orientation and/or gender identity. Network Pharmacy Providers should be aware of any indications related to abuse, neglect, national origin and/or exploitation, and report any concerns to the appropriate state agency when warranted. Training on these topics is provided at the following link: <https://professionals.optumrx.com/resources/fwa-compliance/fwa-training.html>

B. Pharmacy audits (Audits) and Claim Reviews

Audit Policy Statement

All Claims submitted to Administrator are subject to audit. The Administrator's Pharmacy Audit Program helps to ensure Claims are submitted and dispensed in accordance with Administrator guidelines, and that Network Pharmacy Providers comply 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 of 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, the original records will not 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 for the term of the Agreement and a period of five (5) years thereafter or in accordance with applicable law.

In addition, and subject to applicable law and regulatory requirements, audit procedures may be temporarily modified by Administrator in the event the normal audit process is impacted due to a state of emergency, including but not limited to an epidemic or pandemic.

Audit Purpose

The purpose of the Administrator policy is:

1. To validate the accuracy of paid claims, contractual compliance, regulatory compliance and/or various aspects of Drug Product inventories;

2. To observe and photograph overall facility operations and conditions; presence of required signage and/or any items requiring documentation;
3. To monitor for, detect/prevent FWA activities and/or transaction submission errors in the billing of Covered Prescription Services including, but not limited to investigating FWA of medications of limited clinical efficacy, and/or potential member health and safety issues.

Audits may take the form of a phone call, on-site visit, desktop audit, internal Claims review, Client-directed/regulatory investigative and/or compliance reviews. Audits generally contain a large number of transactions; including but not limited to, a comprehensive review of Prescriptions, proofs of delivery, and any other supporting documentation; credentialing details; licensure review; confirmation of work and facility/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 for Claims determined by Administrator to be discrepant as a result of an audit 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) calendar days of demand for payment.

Administrator routinely monitors and audits the online POS System Claims data. In order to conduct these audits, Administrator may contact Network Pharmacy Providers by telephone, mail, fax and/or e-mail. Network Pharmacy Providers are required to provide records as requested.

Procedures for Audit Compliance

In general, the Administrator will provide the Network Pharmacy Provider no less than two (2) weeks advance written notification of an 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. Administrator or its designee shall have the right, with or without notice, at reasonable times, to conduct a brief compliance check and a standard inventory shelf check.

Network Pharmacy Providers are required to maintain Prescription records (including copies of Prescriptions and signature logs/proof of delivery) 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.

- Network Pharmacy Provider will be contacted within seven (7) calendar days prior to onsite audit with written or oral confirmation of date and an approximate time.
- 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, which is a breach of the audit provisions of the Agreement. The Network Pharmacy Provider may be subject to immediate suspension or termination for noncompliance.
- 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.

- Auditors will attempt to minimize any disruption of business processes while onsite.
- Network Pharmacy Provider will provide Auditors a safe workspace with a sufficient work surface that is well-lit and clutter-free, with access to an electrical outlet and within the confines of the Pharmacy. Work area can be located away from the busiest areas of the dispensing department; however, Network Pharmacy Provider must provide easy access to the required documents outlined in the audit notice.
- Auditor must be given full access to facilities used to support dispensing of Covered Prescription Services billed to Administrator, including, but not limited to, refrigeration unit used to store Drug Products, compounding area, Drug Product storage area, etc. and Network Pharmacy Provider staff will accompany Auditor at all times.
- 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 and items of facility reviews 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 or other proof of payment as deemed acceptable at the Administrator's sole discretion, 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 to extend the original desk audit or onsite audit. A denial of this request will be determined to be denial of access.
- 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) calendar 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) calendar 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 or authorized prescriber statements, as approved by Administrator. Verbal orders and annotations obtained and documented prior to dispensing are accepted at the time of the initial records request but not after the initial records request.
- 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 audit and acknowledges non-cooperation with such on-site audit 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) calendar 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 of Covered Prescription Service or Services for any Claims submitted to Administrator must be made from a source that is both NABP Drug Distributor Accredited (formally known as VAWD) and licensed as drug wholesaler, as regulated by state and federal entities. This requirement includes the purchase of non-legend items (e.g. OTC, supplies); therefore, purchases for these products must be made from a source that is qualified to obtain a drug wholesale license based on their product mix. Non-legend items such as diabetic testing supplies for which Covered Prescription Services are rendered are subject to the requirement to be purchased from a source that is both an NABP Drug Distributor Accreditation and licensed as a prescription drug wholesaler. 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), DEA and ability to obtain DSCSA – compliant transaction history, information and statement as requested for Drug Products. Network Pharmacy Provider must promptly comply with any requests to produce such documentation. Any inter-pharmacy transfers or purchases made through intermediary third parties or marketplaces must be accurately and completely documented in a manner consistent with federal/state laws, as well as industry standards and further documentation may be required to validate the purchases. Any inter-pharmacy transfers or purchases made through intermediary third parties or marketplaces for the purpose of increasing or replenishing stock, and not made to fulfill a specific patient need for an identified patient, are subject to the requirement to obtain transaction history, transaction information, and a transaction statement for the product. If purchases were made to fulfill a specific patient need, supporting documentation must be available and provided, if requested.
- A Network Pharmacy Provider may transfer inventory to alleviate a temporary shortage or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another

pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and non-legend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP Drug Distributor Accreditation and licensed drug wholesaler, to include DSCSA – compliant transaction history, information and statement.

- On the day the Drug Products or medical supplies are transferred, a complete inventory must be taken which documents the drug name, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, documents must indicate the supplier or manufacturer's name, address and registration number. All records involved in the transfer must be maintained and accessible for five (5) years.

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, proof of copay collection, documentation to support copay reduction or waiver, 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 CMS10146 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, dosage form 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, as well as insulin.

Network Pharmacy Providers are required to validate the authenticity, integrity, security and confidentiality of prescriptions transmitted to the pharmacy. The NCPDP's Electronic Signature Guidance white paper provides clarification to prescribers, pharmacies and third-party auditors on the best practices to validate electronic signatures associated with electronic prescriptions. Network Pharmacy Providers are expected to adhere to the NCPDP Electronic Signature Guidance unless otherwise specified in applicable state laws and regulations.

Based on the NCPDP guidelines, digitized signatures are considered similar in methodology to a rubber-stamp signature and thus are not considered valid electronic signatures. The following data elements should be present on an electronic prescription as authentication of electronic signatures for auditing purposes:

- Transaction Identifier
- Prescriber Identifier(s)

- Written Date
- Designated Agent (if applicable)

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. Update must also include the assignment of a new Prescription number.

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 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 drug strength, formulation, directions for use, quantity or days supply are changed, require either a written individualized, annotated authorization on the prescription or a new hard copy prescription to be issued. When the Prescriber writes "as directed", a verification of 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 and must be on the prescription label.

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. Documented annotations must include the date of the clarification(s) and the agent that provided the clarification(s).

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 and NABP Drug Distributor Accreditation, to include valid licensure in the state the covered prescription service or services dispensed. Purchases for any Clean Claims submitted to Administrator must be made from a source that is licensed as a drug 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 the source is authorized to include state or federal licensure, oversight by regulatory agencies to include the Food and Drug Administration (FDA) and 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 or the wholesaler does not have NABP Drug Distributor Accreditation and/or is not licensed as a drug wholesaler, Administrator may immediately offset 100% of the amount for any of the paid claims in question. Network Pharmacy Provider shall remain responsible for the validation a wholesaler, from which they are provided covered prescription service or services, has valid pedigree. Network Pharmacy Provider shall maintain adequate records to further validate purchases from wholesalers to include canceled check information available for Audit. Adequate records are proof of purchases which indicate price, drug name, dosage form, strength, NDC, lot number and quantity.

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 appointed/authorized 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.

Network Pharmacy Provider is authorized to utilize pharmacy employees under a W-2 status to deliver, at no additional cost to the Member, covered prescription services to Members within a 100-mile radius of the pharmacy's physical location. In unique and/or limited single events, Administrator reserves the right to grant a waiver to deliver beyond the designated limits for covered prescription services delivery.

- 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 Member's appointed/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

When submitting a claim, Network Pharmacy Provider may only submit the NDC associated with the actual insulin or diabetic supply filled and dispensed with a prescription. Provider may not submit DME products that are for non-retail use. Diabetic insulin and supplies must be calculated to accurately submit the days' supply. The submitted days' supply and quantity must accurately reflect the prescribed directions and quantity, taking into consideration manufacturer recommendations regarding storage and handling. Directions notated as needed or as directed, or directions without specific, calculable directions (e.g., directions have a sliding scale but no maximum daily dose), require a documented interaction with the Prescriber or Member identified 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, the prescription label and calculate the day supply by using the maximum (up to) daily dosage. The directions may be obtained by direct communications with either the Member or Prescriber. Documented annotations must include the date of the clarification(s) and the agent that provided the clarification(s).

Inhalers and Inhalation Products

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 15-20 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).

GTTS/Day	2.5ml	5ml	10ml	15ml
One	37-50	75-100	150-200	225-300
Two	18-25	37-50	75-100	112-150
Three	12-16	25-33	50-67	75-100
Four	9-12	18-25	37-50	56-75

Note: 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.

Medications Designated as Dispense in Original Container

OptumRx reserves the right to recover payment for claims dispensed outside of the manufacturer's FDA approved storage and dispensing recommendations. Claims for products where the manufacturer's original package is designed and intended to be dispensed to patients without repackaging due to stability and patient safety concerns, may be subject to review and recovery. Pharmacies are advised to follow FDA requirements.

Desktop and Telephone Audits/Reviews

Administrator conducts desktop audits, investigational audits, and claim reviews to verify the accuracy and validity of Claim submissions. Network Pharmacy Providers are typically contacted via telephone, fax, email 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 (e.g., electronic records of new prescriptions, refill authorizations, clarifications and/or annotations), 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.

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. Provider is required to correct the claims through resubmission if requested by Auditor.

- Network Pharmacy Provider is required to answer reasonable telephone, fax, email or mail 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 claim review is related to a Member complaint, Network Pharmacy Provider shall respond to claim review requests within three (3) business days.

Prescription Validation Reviews

Administrator conducts limited scope prescription validation reviews for quality assurance purposes ("PVRs"), which are distinct from and are not considered audits. PVRs are utilized to verify the accuracy and validity of

prescription claim submissions. Claims are monitored on a daily basis for appropriateness and potential billing errors and selected for review. Network Pharmacy Providers are typically contacted via fax or email and asked to provide photocopies of specific documents and records related to its claims submitted to Administrator. Requests for records are made for single claims. Network Pharmacy Provider will generally receive seven (7) business days, unless otherwise indicated on the request for records, to provide the necessary documentation needed to satisfy the review. Network Pharmacy Provider is required to answer reasonable fax or email inquiries from Administrator to validate a Member being billed, prescription directions, compounded drug ingredients, quantities being dispensed, etc.

Investigative Reviews

Administrator conducts investigational reviews to verify the accuracy/validity of Claim submissions, as well as verification of Drug Product and supply purchases. Investigative reviews may be performed as on-site or desktop audits, and encompass all requirements listed in Section B. Pharmacy Audits (Audits) of this manual. Requested documentation may include, but is not limited to, original Prescriptions, signature logs, computer records (e.g., electronic records of new prescriptions, refill authorizations, clarifications and/or annotations), distributor year-to-date summaries or invoices of each wholesaler/distributor supporting all Drug Products, including DME purchases and returns. Network Pharmacy Provider will receive fourteen (14) 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 no less than a ten (10) business day appeal timeframe to submit any additional documentation needed to refute the findings.

Note: All distributor purchase summaries or invoices of each wholesaler/distributor must come directly from the wholesaler/distributor. Summaries or invoices 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

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, and where cumulative errors rise to the level of negligence or potential FWA, as determined solely by Administrator, 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 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 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 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)
- Inappropriate billing of prescriptions that were intended to be reversed (e.g. test claims, patient did not want prescription).
- Inappropriate billing of prescriptions that may impact a patient's safety (e.g. over the maximum recommended dosing per the manufacturer package insert without consultation with the prescriber, repackaging of medications against manufacturer's FDA-approved requirements).

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 or changing the days supply to obtain multiple dispensing fees or undermine Prior Authorization or quantity limits, etc.
- Billing multiple lower strengths when one higher strength Drug Product is prescribed.
- Billing for a 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.
- Again, the above is only a partial listing of sample audit violations. For a more complete list of potential audit violation[s] and discrepancy descriptions, please see the Appendix E.

Administrator reserves the right to recoup payment[s] previously paid to a Network Pharmacy Provider for Claims that are later determined by Administrator to be discrepant Claims.

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).

In situations where cumulative errors rise to the level of negligence or 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.

Instances of alleged FWA identified at the conclusion of an audit may subject Network Pharmacy Provider to immediate termination. 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)
- 5 = Pharmacy/Transfer

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

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

Pharmacy Audit Review Committee (PARC)

Administrator maintains an ongoing Pharmacy Audit Program to ensure Network Pharmacy Providers are in compliance with their Pharmacy Services Agreement. Administrator has established 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 final audit determination. The PARC process is not applicable or available to Network Pharmacy Providers going through or that have completed the termination and appeal process, disciplined or otherwise the subject of an investigation for other reasons associated with suspected fraud, including prescriber denials, Member denials, or inventory shortages.

Network Pharmacy Provider must respond to the initial audit request and exhaust any and all appeal options to qualify for a PARC review. Please be aware, the PARC process is not a vehicle for submission of new materials for inclusion in the audit review; however, is designed to provide a re-determination of previously submitted documentation during the standard audit process. New materials submitted to the PARC will not be reviewed by the Committee.

Pharmacies that disagree with Administrator’s final audit findings and are eligible for a PARC review are given a one-time opportunity to respond to final audit findings by submitting a written request for reconsideration within

thirty (30) calendar days from the date of the final audit report.

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 involved in the audit being reviewed.

Administrator may begin offset of audit finding amounts against any future payments due to Network Pharmacy Provider prior to the outcome of the PARC process.

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

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.

Documentation of a valid prescription order shall be comprised of a signed Prescriber's order and a medication administration record (MAR) for a time period that supports the audited dates of service. All signed Prescriber's orders must be supplemented by a MAR to help ensure Members are receiving the appropriate therapy and not therapy that has been discontinued or changed since the last Prescriber's order. Network Pharmacy Providers are expected to adhere to these requirements for what constitutes a valid prescription order unless otherwise specified in applicable state laws and regulations. Record retention is important, and timely retrieval of these documents shall be in compliance 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 January 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.

State Specific Requirements

Nebraska: Audit of Pharmacy Records. Administrator will adhere to the auditing requirements of Neb. Rev. Stat. §44-4607.

New Mexico: Audit of Pharmacy Records. To the extent required by N.M. Stat. Ann. § 61-11-18.2(8), an audit of the records of a Pharmacy by Administrator shall not exceed two years from the date the claim was submitted to or adjudicated by Administrator, unless it conflicts with state or federal law.

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/Preclusion List Validations

Network Pharmacy Provider must have a policy and procedure for checking the Office of Inspector General's (OIG) – U.S. Department of Health & 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 Pharmacy Programs at: pharmacyprograms@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 & 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 & Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE): [Exclusions | Office of Inspector General | U.S. Department of Health and Human Services \(hhs.gov\)](https://www.oig.hhs.gov/exclusions/)
- Centers for Medicare & Medicaid (CMS) – Preclusion List: Please be aware that Medicare Advantage and Part D Plan sponsors are prohibited from paying claims for entities included in the Medicare Preclusion List. Notifications will be issued to impacted entities if we determine the prescriber or other entity is on the Preclusion List and claims will not be paid.
- General Services Administration (GSA) – System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS)

You are required to report any suspected or potential FWA.

To report an incident, please contact Pharmacy Programs: 800-613-3591 or via email pharmacyprograms@optum.com.

Client(s) or Benefit Plan Sponsors, FDR entities (including Network Pharmacy Providers) should initiate an inquiry immediately, but no more 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)

IX. 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).

Network Pharmacy Provider shall maintain adequate inventory of prescription Drug Products and supplies. 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.

Network Pharmacy Provider shall provide Administrator with any report(s), data or other information which Administrator may reasonably request in a format, via a medium, and at a frequency reasonably determined by Administrator or Administrator's Clients or as otherwise required by applicable laws and regulations. Network Pharmacy Provider shall be responsible for the integrity and accuracy of all data furnished or transmitted by Network Pharmacy Provider to Administrator or Claims Processor and shall correct all errors in such data within ten (10) business days of being made aware thereof. To the extent such reports, data or other information is required for compliance with applicable laws and regulations, including but not limited to Medicare Laws and Regulations, Network Pharmacy Provider shall certify as to the accuracy and validity of such report, data or other information prior to submission to Administrator. If Network Pharmacy Provider fails to timely comply with providing Administrator with any reports, data or other information required by applicable laws or by any Government Authority, Network Pharmacy Provider shall reimburse Administrator for any penalty, fine, etc. incurred by Administrator or Administrator's Clients.

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, unless the ability to opt-out is otherwise required by applicable law.

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.

As applicable, Company shall provide services to Members in the same manner and in accordance with the same standards as Company provides services to its other Members. Company shall not discriminate against any Member in its provision of Covered Prescription Services for any reason, including, but not limited to, race, sex, color, religion, national origin, age, gender, marital status, physical or mental handicap, sexual orientation, ancestry, disability, utilization of medical or mental health or substance use disorder services or supplies, health status, health insurance coverage, sexual preference or status as a Member.

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.

Dispensing or distributing Prescription Drugs/Drug Products which are not based on valid prescriptions for individually identified Members or are otherwise on pre-populated or templated prescriptions is prohibited. Such pre-populated prescriptions may also not include options for substitute products without individualize prescriber authorization or annotation.

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), directly or indirectly utilize any unmanned or manned aerial vehicle, machine or device, including drones and/or any autonomous vehicles and/or third party rideshare or delivery services including Uber, Lyft, Doordash, Grubhub, except upon the advance written approval of Administrator, which approval may be refused at Administrator's sole discretion.

Non-Compliance

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. 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. The Pharmacy or Network Pharmacy Provider shall not refuse to provide service or any Covered Prescription Service to any Member, except for a specific clinical reason or if doing so violates applicable law. Non-compliance may include, but is not limited to, the disclosure of confidential information or data, submitting an incorrect DAW code, submitting an inaccurate U&C price, submitting incorrect Claim submission data, submitting an incorrect NDC number, 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, non-reimbursement of claims associated with non-compliance, recoupment of previously reimbursed claims associated with such non-compliance from amounts owed to Network Pharmacy Provider, and termination of the Agreement.

Interference with Administrator Relationships

Network Pharmacy Provider is prohibited from interfering with or disrupting an Administrator relationship with an existing Client or potential client. Violation of this prohibition shall subject Network Pharmacy Provider, in addition to other rights and remedies as may be available to Administrator at law, equity, and under the contract, to immediate termination from participation in any network.

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 appeal such termination, if applicable.

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.

Delegation and Off-Shoring

Network Pharmacy Provider shall not delegate or offshore any service, activity or other obligation required of it under the Agreement, as amended, (including the provision of Covered Prescription Services by Network Pharmacy Provides to Plan Members), to an Affiliate or third party, without the prior written consent of Administrator (which consent shall not be deemed to create any liability for Administrator whatsoever unless otherwise required by applicable law), and when necessary, all applicable Clients, as determined in the sole and absolute discretion of each of them, as may be communicated by Administrator. No consent may be obtained until Administrator has received a fully executed copy of each agreement between Network Pharmacy Provider and a delegate that relates to the proposed delegation. Any such agreement must provide that it will terminate (i) completely if Administrator revokes an agreement on the delegation or (ii) as to an affected Client if the Client revokes the delegation. Any such delegation, if consented to (an "Approved Delegation"), shall be performed by the delegate in accordance with the Clients' respective contractual obligations and in accordance with Network Pharmacy Provider's contractual obligations hereunder. Network Pharmacy Provider agrees that any agreements of Network Pharmacy Provider with respect to an Approved Delegation shall be in writing, signed by the parties to be bound thereby and in compliance with all applicable laws and regulations. In the event that a delegate of Network Pharmacy Provider fails or is unable (for any reason whatsoever) to perform in a satisfactory manner any services, activities or other obligations which have been sub-delegated pursuant to an Approved Delegation, then Administrator or any affected Client shall have the right to suspend, revoke or terminate such Approved Delegation effective upon the date set forth in a written notice furnished to Network Pharmacy Provider and Network Pharmacy Provider shall continue to be responsible to perform such duties and obligations of the Agreement. Additionally, an affected Client shall have the right to institute corrective action plans or seek other

remedies or curative measures respecting the unsatisfactory Approved Delegation consistent with applicable laws and regulations. Any attempted sub-delegation by Network Pharmacy Provider which is not an Approved Delegation shall be null and void and of no force or effect.

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 is partnering with NCPDP as the aggregator of credentialing and 42 CFR 455 required data for participation in Administrator's provider networks. All Network Pharmacy Providers are required to update/maintain both Part 1 and Part 2 of their pharmacy profile online with NCPDP, in addition to their demographic and service information.

Administrator may require, at its sole discretion, pharmacies applying to participate in Administrator's provider networks to complete and maintain both Part 1 and Part 2 of their pharmacy profile online with NCPDP in lieu of Administrator's proprietary Credentialing Application. This information includes, but is not limited to, the social security numbers (SSN) and dates of birth of all applicable persons per Part 2 of the pharmacy's profile online with NCPDP.

Administrator may deny or terminate Network Pharmacy Providers from participation in any or all networks for failure to complete, maintain or provide accurate information with NCPDP, including Part 2 of the pharmacy's online profile.

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 abides by applicable state guideline requirements for credentialing and re-credentialing completion time. 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 applicable per federal/state law and regulation.
- 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 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 shall give Administrator and/or PSAO advance notice as soon as practicable of any anticipated closing of provider's facility. If it is not possible to give advance notice of the closing of a site, Network Pharmacy Provider shall notify Administrator and/or PSAO immediately when the site is closed.
- Network Pharmacy Provider must provide a written notice to Administrator at PharmacyCredentialing@optum.com at least 30 days prior to change of ownership and assigning the Pharmacy Network Agreement to any other person or entity. Network Pharmacy Provider may not assign the Pharmacy Network Agreements to any other person or entity without the prior written approval of the Administrator at its sole discretion of Administrator. Any attempted assignment by Network Pharmacy Provider without the prior written approval of Administrator will be void and of no force and effect. In the event Network Pharmacy Provider makes a valid assignment to a successor with the prior written approval of Administrator, any successor to ownership will be responsible for copy of Bill of Sale and

Power of Attorney to the Administrator at PharmacyCredentialing@optum.com. The successor will be responsible for all liabilities and obligations of its predecessor under the Pharmacy Network Agreement, such approval may be subject to re-credentialing requirements.

- Network Pharmacy Provider must notify Administrator in writing if:
 - Network Pharmacy Provider's license/permit is in jeopardy of being suspended or revoked.
 - Network Pharmacy Provider receives notice of any proceedings which may lead to disciplinary action.
 - 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;
 - There is a subpoena of records related to Covered Prescription Services or Network Pharmacy Provider's business conduct; or
 - There is a seizure by law enforcement of Network Pharmacy Provider's Prescription records, computer systems, financial records, accounts or real property.
- Re-credentialing is completed every three years.

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, the pharmacy must be open and operating for a minimum of six months under the current ownership and 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's 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's 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
11000 Optum Circle
Eden Prairie, MN 55344

Email address: pharmacycredentialing@optum.com

Mail Delivery Pharmacy Additional Credentialing Requirements

Any pharmacy requesting mail order pharmacy network access must execute the Mail Order Pharmacy Network Agreement, pass Mail Order Pharmacy Credentialing, be licensed in all states the pharmacy Mails into and

agrees to the terms and conditions of the Mail Order Pharmacy Agreement. At a minimum, pharmacy must be accredited with NABP Digital Pharmacy Accreditation, formerly known as VIPPS and accredited by URAC, formerly known as Utilization Review Accreditation Commission or Accreditation Commission for Health Care (ACHC) for the applicable accreditation.

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

- NABP DPA: <https://nabp.pharmacy/programs/digital-pharmacy/>
- URAC: urac.org
- ACHC: achc.org

Specialty Credentialing

The OptumRx Specialty Pharmacy Network is a narrow network. Participation in the network is through leveraging Any Willing Provider Laws and successfully passing a multi-step application process. A pharmacy successfully passing the multi-step application process does not fully grant access by Network Pharmacy Provider to dispense Specialty Drug Products for all Clients or Benefit Plan Sponsors. The initial minimum requirement of all Network Pharmacy Providers applying to the network is that they must be URAC accredited in Specialty Pharmacy and they must also be accredited with one of the following: ACHC in Specialty Pharmacy, Joint Commission or Pharmacy or NABP in Specialty Pharmacy.

To obtain information on applying to the OptumRx Specialty Pharmacy Network, please contact: orx_specialty_pharmacy_network_request@optum.com

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

- URAC: urac.org
- ACHC: achc.org
- The Joint Commission: jointcommission.org
- NABP: nabp.pharmacy

- ❖ Florida: Florida providers that are designated as an essential provider by the Agency for Health Care Administration, designated as a Cancer Center of Excellence, designated as an Organ Transplant Hospital, designated as a Specialty Children's Hospital, or a regional perinatal intensive care center are only eligible for contracting of administration or dispensing of covered prescription drugs, including biological products, which are administered through infusions, intravenously injected, or inhaled during a surgical procedure or are parenteral drugs, as part of onsite outpatient care. To obtain additional information regarding network participation, please contact: orx_specialty_pharmacy_network_request@optum.com

Compound Credentialing

Compound Credentialing Administrator requires Network Pharmacy Providers to meet additional credentialing requirements prior to being allowed to process Compounded Drug Claims. Administrator will accept credentialing from a third-party entity which is subject to change at Administrator's sole discretion. Network Pharmacy Providers will be required to meet and maintain all of the credentialing standards established by Administrator and/or the third-party credentialing entity (i.e. PCAB or NABP's compound accreditation). Network Pharmacy Providers will also be required to meet an ethics management compliance review, which includes, but is not limited to, a review of business operations, sales/marketing conduct, and compounding code of conduct, an on-site facility review and compliance with applicable laws such as Anti-Kickback, Stark law, as well as federal/state pharmacy practices requirements.

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 contact: optimized.credentialing@optum.com

PSAO Credentialing Requirements

If you are a PSAO or a pharmacy contracted with a PSAO for participation in the Administrator's networks:

- The PSAO must certify pharmacies affiliated with the PSAO whom has been operational for a minimum of six months under current ownership.
- The PSAO must meet the Administrator's requirements, including the presence of an ongoing acknowledgement, understanding and agreement 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 shall require all affiliated Network Pharmacy Providers to update, maintain and complete pharmacy's NCPDP online profile, including Part 2.
- 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 & 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 & 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;
- 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>
- 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 & 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:

- Office of Inspector Generals (OIG) — U.S. Department of Health & Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE) — oig.hhs.gov/exclusions/index.asp
- Centers for Medicare & Medicaid (CMS) – Preclusion List- Please be aware that Medicare Advantage and Part D Plan sponsors are prohibited from paying claims for entities included in the Medicare Preclusion List. Notifications will be issued to impacted entities if we determine the prescriber or other entity is on the Preclusion List and claims will not be paid.
- General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS) — sam.gov/portal/SAM/#1

Enhanced Credentialing

Administrator or its designee, at Administrator's sole discretion, may perform an in-depth level of credentialing of pharmacies, including on-site visits (i.e. enhanced credentialing) prior to or after contracting and participation in some or all of Administrator's networks, including Medicare Part D, UHC Individual and Family Plan (IFP), as well as Medicaid networks. Successful completion of enhanced credentialing may be a prerequisite in select CMS designated and surrounding areas. Enhanced credentialing applies to both directly and in-directly contracted pharmacy locations. Network Pharmacy Provider, 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, or failure to pass enhanced credentialing may result in denial, exclusion or termination of network participation for a minimum of one (1) year.

As a Network Pharmacy Provider you are required to provide, when requested by Administrator, a complete dispensing history for period of time requested, which may include a period prior to being a contracted provider. Dispensing information shall include all prescription transactions, regardless if billed directly to the Administrator. The provided report shall not include any Protected Health Information (PHI) of Members or any financial or payments made to the Provider. Administrator may require, at its sole discretion, affiliated Network Pharmacy Providers undergoing enhanced credentialing to complete all of their credentialing information with NCPDP in lieu of Administrator's proprietary Credentialing Application. This information includes, but is not limited to, the social security numbers (SSN) and dates of birth of all applicable persons per the NCPDP credentialing format.

Onsite visit

Administrator or its designee shall have the right, with or without notice, at reasonable times, to access, inspect, 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 visit and acknowledges non-cooperation with an on-site visit 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/or quality of service complaint and confirms with Network Pharmacy Provider the occurrence of such dispensing error or service issue. Network Pharmacy Provider will (i) review the information with the Member (ii) document the event/issue based on Network Pharmacy Provider's internal policies and (iii) report the error/service issue 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.

Storage of Refrigerated Medication

Network Pharmacy Provider shall adhere to the following requirement; The refrigerator and freezer are dedicated for the storage of medication items only and shall not be used for the storage of anything else (i.e. food & beverages in open or closed containers as well as any other non-medication items) Network Pharmacy Provider shall maintain and document a temperature log, electronically or written, of the medication refrigerator and freezer checked at least once per day.

Pharmacy Temperature and Storage Conditions

Network Pharmacy Providers shall take appropriate measures to ensure compliance with the following guideline set forth by the USDA regarding medication's therapeutic integrity; "all prescription drugs shall be stored at appropriate temperatures and under appropriate conditions in accordance with requirements, if any, in the labeling of such drugs, or with requirements in the current edition of an official compendium, such as the United States Pharmacopoeia/National Formulary (USP/NF). If no storage requirements are established for a prescription drug, the drug may be held at 'controlled' room temperature, as defined in an official compendium, to help ensure that its identity, strength, quality, and purity are not adversely affected.

Operation Standards

- Minimum hours of operation - Network Pharmacy Provider to be open for a minimum of 20 hours per week in order to adequately serve the needs of the OptumRx patients.
- Pharmacy personnel identification (Name tags) - The staff of all Network Pharmacy Providers are required to display on their person- their name and title while on duty.

D. Pharmacies Contracted Directly with 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.

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 submit a Network Participation Request form located on our website: <https://professionals.optumrx.com/resources/forms/provider-network.html>.

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. Medicaid; Federal/State Medicare-Medicaid Enrollee (MME) Regulatory Requirements

Particular states and CMS also have certain IFP and Medicaid, as well as MME, regulatory requirements, including specific provisions to be included in all Client and Benefit Plan Sponsor sub-contractor Agreements. For further information, please see the Appendix F. 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.

State-specific Medicaid Program Participation Required

Network Pharmacy Providers wishing to participate in Medicaid pharmacy networks and dispense Covered Prescription Services to eligible Medicaid beneficiaries are required to have met the enrollment requirements of the applicable state's Medicaid program, as well as have obtained a Medicaid Identification Number in that state. To avoid potential disruption in payment for states requiring Medicaid Identification Numbers, Network Pharmacy Providers must update their pharmacy's profile on the NCPDP website to list their Medicaid identification numbers for each applicable state.

As directed by clients, Administrator may reject claims from Prescribers and/or Pharmacies who have not met the

enrollment requirements of the applicable state. Prescriber claims may reject with the NCPDP Rejection Code 889 - Prescriber Not Enrolled in State Medicaid Program. Pharmacy claims may reject with the NCPDP Rejection Code 890 - Pharmacy Not Enrolled in State Medicaid Program.

Medicaid COB

Medicaid is the payer of last resort. If another insurer or program has the responsibility to pay for costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the Claim prior to Medicaid making any payment. This is known as Third Party Liability (TPL). Third parties may include, but are not limited to: private health insurance, Medicare, employer-sponsored health insurance, workers' compensation, long-term care (LTC) insurance as well as other state and federal programs.

Third party payers are not responsible for reimbursing Medicaid for any services that are not covered under the Medicaid State plan.

State Sanctioned Providers

State regulations prohibit the Administrator from paying Claims for Drug Products written by Providers who have been excluded from participation in Medicaid programs. As directed by clients, Administrator will reject claims from Providers who have been excluded from Medicaid program. Prescriber claims will reject with the NCPDP Rejection Code A1 accompanied by the message "Prescriber Not Covered — State Sanction" to identify those Prescribers associated with a state-level sanction.

Pharmacy claims will reject with the NCPDP Rejection Code 559 accompanied by the message "ID Submitted is associated with a Sanctioned Pharmacy" to identify those Pharmacies associated with a state-level sanction.

Medicaid Drug Management Program Member Pharmacy Lock-in Edit

Federal laws require Medicaid agencies to implement utilization control programs that allow Medicaid plans to temporarily restrict the pharmacy(ies) and/or prescriber(s) from which a beneficiary may obtain drugs only when that beneficiary has obtained drugs at a frequency or amount that is not medically necessary. These Medicaid drug restriction programs, also called "lock-ins," usually focus on opioids and other frequently abused medications.

A Provider Restriction Edit is triggered for Members who are locked into designated providers. If a Member is locked into a certain pharmacy or prescriber for specific drugs, claims may be rejected with two reject codes: M2 "Recipient Locked In" and 70 "Prod/Service Not Covered", and with one of the following messages "Member Pharmacy Override Exclusion" or "Member Prescriber Override Exclusion" respectively. If a pharmacy has a claim rejected with reject code M2 and/or 70, the pharmacist should advise the Member to contact their health plan at the number on the back of their ID card. The health plan will provide the Member with the details of why the prescription was rejected and how the Member can resolve the issue.

The plan reserves the right to add, delete, or modify their policies associated with the lock-in program to comply with state-specific regulatory requirements.

Terminated NDCs Due to Pharma Manufacturers Not Renewing Their Medicaid Drug Rebates Agreements

In 2018, CMS made changes to the National Drug Rebate Agreement (NDRA) and mandated that manufacturers must sign the updated agreement to continue their participation in the Medicaid Drug Rebate Program no later than September 30, 2018.

Effective October 1, 2018, CMS terminated the existing rebate agreement(s) for manufacturers that did not sign the updated NDRA by September 30. According to the Health and Human Services (HHS) guidance, claims for NDCs where the labeler has no NDRA in place will not be funded by the state Medicaid agencies, and may be denied at the point of sale.

Effective October 1, 2018, Medicaid plans may remove certain NDCs from the formulary for which the corresponding manufacturers failed to update their Medicaid NDRA.

With that, Medicaid plans may be rejecting previously paid NDCs from such manufacturers with the NCPDP rejection codes “AC” (“Product Not Covered Non-Participating Manufacturer”) or “70” (“Product/Service not Covered”).

If such rejections are received, OptumRx would like to remind pharmacists and technicians that you should:

- Process the claim using an alternate approved NDC, and/or
- Work with the prescriber to obtain a new prescription for an alternative approved product if necessary, and;
- Advise Members that their medications may have a different appearance.

Please work with Medicaid Members and /or providers to transition to an approved NDC to ensure continued adherence. If further assistance is needed, please call the Pharmacy Call Center at the telephone number shown on the Member's ID card. This applies to both Medicaid Managed Care and Fee for Service (FFS) Plans.

F. 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 to 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.

The purpose of the retail network is to provide Covered Prescription Services to Members at point of sale. Therefore, mailing of any Covered Prescription Service whether by a pharmacy, an affiliated or unaffiliated entity on behalf of a pharmacy or by a representative or authorized agent of the Member is prohibited.

Additionally, Pharmacy shall not (directly or through a third-party, including telemarketers) obtain Members and/or obtain prescriptions for Members via: (i) cold-calling; (ii) obtaining a Member's primary care provider or billing information without the knowledge and authorization from the Member; (iii) contacting or offering to contact a prescriber on a Member's behalf without the Member's express knowledge and authorization for each specific claim. Pharmacy shall not engage in misleading or deceptive practices, including initiatives to obtain a prescription from a prescriber not expressly requested by the Member or by suggesting to a Member that his/her prescriber wants the Member to receive the medication without the prescriber's express knowledge and authorization. Network Pharmacy Providers are required to maintain documentation showing the Member or Member's appointed/authorized representative consent to enroll in automatic refills with the pharmacy.

Administrator provides limited authorization to Network Pharmacy Providers participating in the Network Compound Credentialing Program (NCCP) to Mail covered Compounded Drugs to Members in those states in which they are licensed and/or authorized to do so; at no cost to the Member unless the Member has specifically requested expedited service, which the Member agrees to pay. NCCP Network Pharmacy Providers are not authorized to Mail covered non-Compounded Drugs unless expressly authorized to Mail such Covered Prescription Services to Members by Administrator. Additionally, it is prohibited to mail any Covered Prescription Drugs to members for those Clients who have opted out and do not participate in the NCCP.

Network Pharmacy Provider 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 Provider locations that deliver covered 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 NABP Digital Pharmacy Accreditation
- 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 prescriptions are mailed.

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

G. 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:

- Undisclosed 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 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 or are otherwise on pre-populated or templated prescriptions. Such pre-populated prescriptions may also not include options for substitute products without individualized prescriber authorization or annotation.

H. 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 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. All relative notifications must be sent to pharmacyprograms@optum.com.
- 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 registration, state license), tax identification (ID) changes Medicaid ID, provider affiliation, ownership information, provider dispensing type.

It is the responsibility of Chain and/or PSAO organizations to ensure 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.

I. 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 encounters abusive and disruptive Members, please see Pharmacy help desk service contact information provided in Section III 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.

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

K. 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);
- 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 in conduct or communication(s), including, but not limited to, contact 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, Addendum 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, GSA and Preclusion 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;
- Any current or future affiliation with a pharmacy that was terminated under any of the above-listed FWA scenarios (e.g. affiliation includes, but is not limited to, any 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 in any manner obscuring ownership and/or affiliation links between the pharmacies).

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 also shall be entitled to suspend payment obligations, including but not limited to cancellation of checks, payment suspension of future cycle checks or restriction of claims submission in order to assure that there are sufficient funds available to recoup claims determined to be discrepant as a result of Network Pharmacy Provider's breach(es) of any provision(s) of the Agreement or PM. Administrator's ultimate remedies under this section include immediate termination of the Agreement.

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 Network Pharmacy Provider or of the Agreement in its entirety. The Administrator will determine the extent to which a breach has occurred. The Administrator will make a determination in regard to participation status or the need for further review and recommendations. Final determination will be made by the Administrator 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. Network Pharmacy Providers that have received notice of disciplinary action may appeal if applicable, whereby the representatives of the pharmacy may submit documentation and relevant information in support of their position for additional review. The appeal panel will review any such additional documentation submitted to evaluate the original decision to terminate.

Network Pharmacy Providers, Members or Prescribers suspected of FWA will be reported to the Benefit Plan Sponsor by Administrator for the appropriate reporting to authorities such as the NBI MEDIC, U.S. District Attorney's Office or Office of Inspector General the appropriate State Board of Pharmacy, and/or State Department of Insurance. In FWA cases involving Medicare Part D Sponsors, Administrator will promptly report such instances to the NBI MEDIC.

L. Alternative Dispute Resolution and Arbitration

The parties agree to work in good faith to resolve any and all Disputes. “Disputes” means any and all issues, disputes, and/or controversies between the parties, including, but not limited to all disputes relating in any way to the parties’ relationship, the terms of the Provider Network Agreement (“Agreement”) and/or or this PM, and the Pharmacy Provider’s status in the Administrator’s network. All disputes concerning the immediate termination or non-renewal of the Agreement or the actual or threatened disclosure of Administrator’s or Client’s Proprietary Information are excluded from the definition of “Disputes.” For avoidance of doubt, all termination disputes are still subject to arbitration.

In the event a Dispute arises—other than with respect to issues giving rise to immediate termination or non-renewal of the Agreement and actual or threatened disclosure of Administrator’s Proprietary Information or Client’s Proprietary Information—the party asserting the Dispute shall provide written notice to the other party describing in detail the nature and scope of the Dispute. Such notice shall be provided promptly and, at the latest, within one year of the facts giving rise to the Dispute. The parties thereafter shall engage in good faith discussions to try to resolve the Dispute. 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, the parties shall each be represented by their leadership representation (or individuals in analogous positions). In the event the parties are still unable to resolve the Dispute, either party may commence arbitration in accordance with the rest of this section, however, any party seeking to commence such arbitration must certify in writing: (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. Any such arbitration shall be administered exclusively by the American Arbitration Association in accordance with its Commercial Arbitration Rules and Mediation Procedures, as they may be amended from time-to-time. For avoidance of doubt, the arbitrator(s) shall decide any and all questions regarding arbitrability or the formation, scope, validity, and/or interpretation of the parties’ agreement to arbitrate. For further avoidance of doubt, all Disputes—including Disputes regarding termination hereof or non-renewal hereof and actual or threatened disclosure of Administrator’s Proprietary Information or Client’s Proprietary Information—are subject to the arbitration process described herein.

All arbitrations under this Agreement and PM in which the amount in controversy of all parties’ claims totals \$1,000,000 or less shall be conducted by one (1) arbitrator, who will be mutually selected by the parties within fourteen (14) days of the initiation of the arbitration. If the parties cannot agree on an arbitrator, then the arbitrator shall be selected by the American Arbitration Association in accordance with its Commercial Arbitration Rules. All other arbitrations under this agreement shall be conducted by a panel of three (3) arbitrators, all of whom must have at least ten (10) years of legal experience in the area of healthcare law or be former judges. For arbitrations conducted by a panel of three (3) arbitrators, within fourteen (14) days of the initiation of arbitration, each party shall select one person to act as an arbitrator and within fourteen days (14) from the date of the appointment of the last party-appointed arbitrator, the two appointed arbitrators shall then select the third arbitrator who shall act as chairperson of the panel. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator, the third arbitrator shall be selected by the American Arbitration Association in accordance with its Commercial Arbitration Rules. All selected arbitrators shall be impartial and independent and shall act as neutrals. The parties can mutually agree, in writing, to vary these deadlines, the venue, and/or the number of arbitrators for any given Dispute.

All arbitrations proceeding under the agreement and PM shall be conducted in Hennepin County, Minnesota except, that arbitrations proceeding under the Agreement and PM with one arbitrator may be conducted by virtual means at the election of either party, and arbitrations proceeding under the Agreement and PM with three arbitrators may be conducted by virtual means with the agreement of all parties. For venue purposes, arbitrations conducted virtually are deemed to have occurred in Minnesota. 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 written notice of the Dispute was given or shall be deemed to have waived its claims in the Dispute, which claims will be deemed forever released.

The arbitrators may construe or interpret but shall not vary or ignore the terms of the Agreement and PM 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.

For all arbitrations under the Agreement and PM in which the amount in controversy of all parties' claims totals \$1,000,000 or less, each party hereby consents to a documentary hearing for all arbitrations, by submitting to the arbitrators, written briefs and affidavits, or declarations, expert opinion, along with documentary evidence. However, the arbitrator(s) shall conduct an oral hearing, if requested in writing by a party, within thirty (30) days after the date set for completion of all permitted discovery. For all arbitrations under the Agreement and PM in which the amount in controversy of all parties' claims totals more than \$1,000,000, the arbitrator shall determine whether parties may present live witness testimony.

After the empaneling of the arbitrator(s), the parties shall have the right to discovery (including without limitation taking depositions) pursuant to the schedule and limits determined by the arbitrator(s) to be appropriate, in light of the needs of the Dispute, to achieve an efficient resolution of the Dispute while preserving each party's ability to fairly present its claims and defenses. Notwithstanding the previous sentence, in an arbitration under the Agreement and PM in which the amount in controversy of all parties' claims totals \$1,000,000 or less, each party shall be limited to a maximum of one deposition per side, absent a finding by the arbitrator of extremely good cause for additional depositions.

The Arbitrators may construe or interpret but shall not vary or ignore the terms of the Agreement and PM. 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, except as required by law, and may not, in any event, make any ruling, finding or award that does not conform to the terms and conditions of the Agreement and PM.

The award rendered by the arbitrator(s) shall be in writing and shall include a statement setting forth the reasons for the disposition of any claim. The award will be binding and judgment on the awards may be entered in any court having jurisdiction thereof.

Regardless of which party prevails in the arbitration, each party shall be responsible for its own fees and expenses in connection with the arbitration, including without limitation its own attorney's fees, except as required by law. In arbitrations proceeding under this agreement with one arbitrator, the parties shall be responsible in equal shares for the fees of the arbitrator. In arbitrations proceeding under this agreement with three arbitrators, each party shall be responsible for the fees of the arbitrator selected by that party, except that the parties shall be responsible in equal shares for payment of the third arbitrator that was selected by the two arbitrators.

The arbitration and the award of the arbitrator(s) shall be maintained by the parties as strictly confidential, except as is otherwise necessary to confirm, vacate, or enforce the award or as ordered by a court in connection with judicial proceedings to confirm, vacate or enforce the award. The parties shall take steps to preserve the confidential nature of the award even in judicial proceedings to confirm, vacate, or enforce the award, including by seeking to file the award under seal.

Notwithstanding judicial proceedings to confirm, vacate, or enforce an award, the parties acknowledge that neither will have the right to litigate a Dispute in court, and that neither will have a right to a trial by a judge or jury, and the right to discovery is limited. **The parties each waive all such rights by agreeing that all disputes must be resolved exclusively in arbitration.**

The parties expressly intend and agree that any Dispute be resolved exclusively on an individual basis and that no other dispute(s) with any third party(ies) may be consolidated or joined with the Dispute. The parties agree that the arbitrators lack any authority to resolve the Dispute as part of a class action, private attorney general, or other representative or consolidated action or proceeding, and that any ruling by the arbitrators to the contrary conflicts with their intent and would require immediate judicial review of such ruling. **The parties agree to arbitrate a Dispute solely on an individual basis and each waives the right to participate in a class proceeding, private attorney general, or other representative or consolidated arbitration or proceeding in connection with any Dispute as claims by third parties will involve different evidence and may result in a delay in resolution of the arbitration. This provision does not prevent the parties from participating in a class-wide settlement of claims.**

In addition, 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 initiate an arbitration under this section.

In the event that any portion of this section or any part of the Agreement or PM 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 the Agreement or PM. If, however, the waiver of class action, private attorney general, or other representatives or consolidated action is deemed invalid or unenforceable with respect to a particular claim, neither party is entitled to arbitration of such claim. Instead, all such claims will then be resolved in a court, after the parties arbitrate any individual claims.

The parties acknowledge that this arbitration agreement is part of a transaction involving interstate commerce and that, notwithstanding any other provision in the Agreement and PM, the Federal Arbitration Act governs both substantive and procedural aspects of this arbitration, including disputes about the interpretation, validity and effect of the Agreement, the PM and any addendums.

This section shall survive any termination of the Agreement and the conclusion of any business dealings between the parties.

M. 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 (collectively, "Proprietary Information"). The parties shall comply with all Laws applicable to the confidentiality, use, disclosure and maintenance of Members' personal information ("Members' 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 any of the terms of this Agreement.

Administrator's 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, formularies, 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. All Administrator's Proprietary Information remains the exclusive property of Administrator.

Network Pharmacy Provider agrees to maintain the confidential nature of such Proprietary Information and not to disclose any such Proprietary Information without the express written consent of Administrator, except as permitted under the terms of the Agreement.

Network Pharmacy Provider shall only use Proprietary Information in connection with the performance of this Agreement or any related Addendum Amendment, Exhibit or Schedule and shall not use the 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 under this PM 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 an actual or threatened violation of this Section, without limiting any other rights and remedies, an injunction to preserve the confidentiality of Proprietary Information may be entered against Network Pharmacy Provider for breach or threatened breach of this Section in any court of competent jurisdiction. In any such action seeking, among other remedies, an injunction for an actual or threatened violation of this Section, the prevailing party shall be reimbursed for all of its costs and expenses (including, without limitation, reasonable attorneys' fees) incurred in connection with an actual or threatened violation of this Section by the other party. This Section shall survive expiration or termination of the Agreement and this PM.

Network Pharmacy Provider acknowledges and 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 for such breach, and that Administrator and/or Client shall be entitled to injunctive relief in any court of competent jurisdiction to prevent a breach or threatened breach of the provisions of this Section, In any such action seeking, among other remedies, an injunction for an actual or threatened violation of this Section, the prevailing party shall be reimbursed for all of its costs and expenses (including, without limitation, reasonable attorneys' fees) in connection with an actual or threatened violation of this Section by the other party.

N. 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.

O. 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.

P. Rural Pharmacy

Upon request, a Network Pharmacy Provider may be eligible for rural Prescription Drug Compensation, if applicable, for a Benefit Plan or network, if Network Pharmacy Provider is physically located more than fifteen (15) miles from another pharmacy's location, per the address on the NCPDP DataQ, irrespective of city, county and state lines. At its sole discretion, Administrator may make reasonable exceptions and may revoke rural Prescription Drug Compensation at any time in the event the Network Pharmacy Provider no longer qualifies to receive rural Prescription Drug Compensation. If granted the rural Prescription Drug Compensation, the Network Pharmacy Provider must notify Administrator within fifteen (15) business days if their qualification changes.

Q. Member and Client Hold Harmless

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.

R. 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 the field 420-DK (Submission Clarification Code), a value of 20 indicates 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)).

This field must be populated for all 340B claims regardless of whether the 340B unit cost is submitted with the claim.

Note: Some states mandate submission of the Section 340B unit cost by submission of the Cost Basis (423-DN) field with the value 08 together with submission of value 20 in the 420-DK (Submission Clarification Code) field. In states with this requirement, 340B claims submitted only with SCC 20 and without the Cost Basis (423-DN) value 08 may be rejected by the plan.

In a situation when the Network Pharmacy Provider also submits the Section 340B unit cost, the two following fields must be populated on a claim, in addition to the Submission Clarification Code:

1. The Cost Basis (423-DN) field with the associated value 08 (which is new with D.0).
2. A Section 340B medication unit cost in Ingredient Cost Submitted (409-D9).

To assist in the identification of 340B claims and increase compliance with duplicate discount avoidance, pharmacies are requested to confirm / report their Physical Location 340B status to NCPDP. This status can be added or updated within the Services tab of your NCPDP profile.

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.

A pharmacy may not know at point-of-sale if a claim qualifies as a 340B claim. At the point the pharmacy is notified or discovers that the claim qualifies as a 340B claim, the original claim must be reversed, and the claim resubmitted as a 340B claim with the correct Submission Clarification Code value of 20.

If the claim has not been corrected to include the correct Submission Clarification Code value, the pharmacy and the eligible entity are at risk for duplicate discounts. Failure to comply may be recognized as a potential breach of contract and may lead to further administrative and/or corrective action including and up to termination from the network.

X. Worker's Compensation and Auto No-Fault



A. Tmesys

- **OptumRx List 3: Prescription Bank Identification Numbers (Rx BINs)**

Tmesys provides nationwide online claims submission, approval and processing for workers' compensation claims as well as certain automobile (PIP) claims in select state. The BIN number is 004261 (Envoy users, BIN is 002538) the PCN is CAL. For the Payer Sheets, click [here](#).

- **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. For additional contact information, please see Contact information provided in Section II of this PM.

Note: With the growth of OptumRx, information may be specific to a legacy BIN/PCN at this time. Please refer to the BIN/PCN information to determine which specific contact information to use.

- Pharmacy Help Desk service contact information
 - Telephone: 1-800-964-2531
 - Email address: OptumWC.PharmacyAssist@optum.com
- Prior authorization (PA) service contact information
 - Telephone: 1-800-964-2531
 - Email address: VitalPointSupport@optum.com
- Pharmacy network contracting department contact information
 - Telephone: 1-855-264-8815
 - Fax: 1-866-576-1656
 - Email address: OptumWC.TmesysNetwork@optum.com
- MAC appeals contact information
 - Telephone: 1-855-264-8815
 - Fax: 1-866-576-1656
 - Email address: macresolution@optum.com
- Pharmacy Communications (Faxblast)
 - Telephone: 1-855-264-8815
 - Fax: 866-576-1656
 - Email address: OptumWC.TmesysNetwork@optum.com
- State Specific MAC Appeals:
 - In accordance with requirements established by certain states call 1-855-264-8815 with questions regarding MAC pricing.
 - To review the Tmesys State Compliance webpage: [State Compliance \(optum.com\)](#)
- 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 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.
- o 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 requirements related to records retention. All relative notifications must be sent to OptumWC.tmesysnetwork@optum.com
- o 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 registration, state license), tax identification (ID) change, provider affiliation, ownership information, provider dispensing type. It is the responsibility of Chain and/or PSAO organizations to ensure the affiliated pharmacies associated with any applicable NCPDP Affiliation Code are effectively updated.

- **Sample Member Identification (ID) Cards**

Below is a sample of a Member ID card representing a one 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 Sample Member identification (ID) cards provided in Section III of this PM.

Sample Tmesys Member ID Cards and Sample Healthcare Solutions Member ID Cards.



- **Processing Claims**

Online processing window to submit an electronic Workers' Compensation Claims to be governed by state law.

- a) **Billing of Claims**

All service Claims must be submitted to Administrator on the POS system using a current version of a NCPDP Claim billing record. All Claims shall be submitted at the time of service, or if online service is interrupted, immediately after resumption of online service. Rejected Claims may be resubmitted up to sixty (60) calendar days after the original date- of-service, unless state laws require more prompt submissions. Covered Prescription Services billed to payor and not received by Member within thirty

(30) calendar days of billing shall be credited to payor by submitting a NCPDP Claim reversal record to Administrator. In no event will Network Pharmacy Provider submit a reversed Claim over thirty (30) calendar days.

- b) **Payment of Claims**

Payment of eligible claims will be made by the entity which has the financial responsibility for the benefit provided to the Covered Person ("Plan"). Administrator is not the Plan. Administrator is responsible for obtaining eligibility from Plan and not under any circumstance shall Administrator have any financial responsibility, obligation or liability to the Pharmacy for the payment of services provided to the Covered Person except to the extent that Administrator has received any such payments.

Payment may be made directly to Pharmacy by Plan or Plan designee involving Administrator. If Pharmacy submits a nonelectronic, paper or out of network bill to Plan, Pharmacy acknowledges

Plan may forward claim to Administrator and Pharmacy agrees to accept the Network rate set forth in its Agreement, from either Plan or Administrator.

If Pharmacy assigns claim to a third party or permits a third party to act as its collection agent, Pharmacy and Administrator agree that payment shall be paid to Pharmacy or its agent at the terms, conditions, and rates set forth in this Agreement. Payment and remittance of eligible claims will be made within 30 days of the date of the twice-monthly processing cycle. Pharmacy shall accept as payment in full the reimbursement established in this Agreement.

In no event shall Pharmacy collect from a Covered Person for a covered prescription an amount not represented as a co-payment, co-insurance, deductible or additional charge in the NCPDP paid claim response. If Pharmacy's usual and customary charge for a service is less than the co-payment, Pharmacy shall not collect from the Covered Person more than the usual and customary charge.

Administrator shall notify Pharmacy immediately upon the failure of any financially responsible entity to fail to pay any Pharmacy billing on the date the payment is due. Pharmacy may in Pharmacy's sole discretion immediately cease to provide service to the entity, entities, or the Administrator.

c) Delegation

Network Pharmacy Provider shall not delegate any service, activity or other obligation required of it under the Agreement, as amended, (including the provision of Covered Prescription Services by Network Pharmacy Provides to Plan Members), to an Affiliate or third party, without the prior written consent of Administrator (which consent shall not be deemed to create any liability for Administrator whatsoever unless otherwise required by applicable law), and when necessary, all applicable Clients, as determined in the sole and absolute discretion of each of them, as may be communicated by Administrator. No consent may be obtained until Administrator has received a fully executed copy of each agreement between Network Pharmacy Provider and a delegate that relates to the proposed delegation. Any such agreement must provide that it will terminate (i) completely if Administrator revokes an agreement on the delegation or (ii) as to an affected Client if the Client revokes the delegation. Any such delegation, if consented to (an "Approved Delegation"), shall be performed by the delegate in accordance with the Clients' respective contractual obligations and in accordance with Network Pharmacy Provider's contractual obligations hereunder. Network Pharmacy Provider agrees that any agreements of Network Pharmacy Provider with respect to an Approved Delegation shall be in writing, signed by the parties to be bound thereby and in compliance with all applicable laws and regulations. In the event that a delegate of Network Pharmacy Provider fails or is unable (for any reason whatsoever) to perform in a satisfactory manner any services, activities or other obligations which have been sub-delegated pursuant to an Approved Delegation, then Administrator or any affected Client shall have the right to suspend, revoke or terminate such Approved Delegation effective upon the date set forth in a written notice furnished to Network Pharmacy Provider and Network Pharmacy Provider shall continue to be responsible to perform such duties and obligations of the Agreement. Additionally, an affected Client shall have the right to institute corrective action plans or seek other remedies or curative measures respecting the unsatisfactory Approved Delegation consistent with applicable laws and regulations. Any attempted sub-delegation by Network Pharmacy Provider which is not an Approved Delegation shall be null and void and of no force or effect.

• Worker's Compensation (WC) or Auto No-Fault

WC and Auto Member eligibility must be verified via the POS System or upon Administrator's prior approval/direction, sent via an alternative method. Possession of a WC or Auto Member identification card is for identification purposes only and does not guarantee eligibility or payment will be made for Covered Prescription Services dispensed. However, if the person's eligibility as a WC or Auto Member is confirmed via the POS System, Clean Claims for Covered Prescription Services will be reimbursed to

Network Pharmacy Provider.

[Kentucky Worker's Compensation Attachment to Member Pharmacy Agreement Notification](#)

All applicable conditions of the provider are incorporated by reference into Section IX: Workers Compensation and Auto No Fault, unless specifically excluded, contradicted by a term in this section, or not applicable by a reasonable interpretation of the manual. More specifically the following sections specifically included for accreditation purposes:

- Section VIII. Compliance; Fraud, Waste and Abuse (FWA); General Training; Audits
- Section VIX. Pharmacy Network Participation Requirements

Reimbursement for worker's compensation (WC) or auto no-fault

Unless expressly permitted by applicable state law and via the POS System, Network Pharmacy Provider shall hold harmless and not collect any Cost-Share for Covered Prescription Services directly from the WC & Auto Member.

For each Clean Claim for a Covered Prescription Service, the Benefit Plan or Administrator shall pay Network Pharmacy Provider the lower of:

- Pharmacy's Usual and Customary price;
- State worker's compensation fee schedule; or
- Prescription Drug Contracted Rate.

Subject to the U.S. Department of Labor, OWCP fee schedule and for other federal programs, Administrator shall reimburse Network Pharmacy Provider pursuant to Section 4.1 of the Agreement for Compounded Drug Covered Prescription Services.

Payment for worker's compensation (WC) or auto Member Clean Claims

Payment may be made directly to Network Pharmacy Provider by Administrator on behalf of the Benefit Plan or its designee. Electronic payment and remittance for eligible Covered Prescription Services will be made within thirty (30) days from the date of the twice-monthly processing cycle. Network Pharmacy Provider shall accept as payment in full the reimbursement established in the Agreement and this PM.

Requirement to submit Claims for all lines of businesses

Network Pharmacy Providers shall submit all Claims for Drug Products and shall dispense Covered Prescription Services to eligible Members for those Clients offering Benefit Plans, such as, but not limited to: workers compensation insurance; no-fault auto insurance; hospice and Cash Discount Card programs in accordance with the terms and conditions of the applicable Agreement.

a) Payment to Pharmacy

For each Claim for service which is eligible for payment, Plan or Administrator shall pay Network Pharmacy Provider the lower of: (1) Network Pharmacy Provider's U&C price; (2) state worker's compensation fee schedule; or (3) the agreed upon price from the applicable Agreement. The agreed upon price from the applicable

Agreement will be expressed as a percentage of average wholesale price for the Drug Product dispensed plus a dispensing fee. The average wholesale price will be based on the price in the Administrator's price file which is updated weekly based upon information provided to Administrator by Medi-Span, Redbook or the publisher of any other nationally recognized Pricing Source. Company acknowledges that Administrator shall be entitled to rely on Medi-Span or the publisher of any other nationally recognized Pricing Source selected by Administrator to determine AWP for purposes of establishing the pricing under the Agreement. Company further acknowledges that Administrator does not establish AWP, and Administrator shall have no liability to Company arising

from the use of the Medi-Span Pricing Guide or information received from any other Pricing Source.

b) Taxes

Pharmacy shall be responsible for and shall pay all sales, goods and services, use, excise, value added and other taxes, tariffs, duties or assessments, including interest and penalties, levied or imposed at any time by any governmental authority arising from or related to any transactions under this Agreement, other than any taxes based on the net income of Administrator.

If Administrator is required to collect any of the foregoing taxes, tariffs, duties or assessments, Administrator shall add same to any invoices and Pharmacy shall immediately pay the same to Administrator.

If Pharmacy is required under any applicable law to deduct from the amounts to be paid to Administrator pursuant to this Agreement any amount on account of withholding taxes or other taxes or levies of any kind, Pharmacy shall pay such additional amounts so that the net amounts received by Administrator are the amounts specified herein.

XI. MedicalRx Specialty Provider Network (MSPN)

MedicalRx Specialty Provider Network was created by OptumRx in response to the high and rising costs of specialty medication management. MSPN is an opt-in network of contracted providers who administer select infused or assisted injection medications. MSPN moves the coverage of these medically administered drugs from the medical benefit to the pharmacy benefit, thereby reducing the significant cost variability or inflation seen across providers and sites of care.

- Contracted providers within the network self-procure medications where they see fit based on their ability to leverage their class of trade or other discounts.
- Network providers continue to administer medications wherever is clinically appropriate and convenient for members.
- Using OptumRx's Specialty Management Access Portal (SMAP) or any standard pharmacy billing software, providers will submit their claims for the medications, materials, and service together to OptumRx.
 - We use National Drug Codes (NDCs), which enables us to employ our pharmacy expertise in driving down medication costs on the medical benefit.
 - In addition to claims submission, the SMAP tool is used for drug coverage verification, reimbursement rates visibility, prior authorization requirements, and viewing claims activity
- Network providers receive prompt and predictable payment at a controlled fair market rate while maintaining high-quality care for patients.
 - Reimbursement amount is confirmed in advance
 - Remittance of payment within 15 days
 - Payment assured for all correctly submitted and approved claims per the MSPN agreement

Specialty Management Access Portal (SMAP)

SMAP is the tool that OptumRx has built to bridge the technology gap allowing contracted medical providers to bill the pharmacy benefit for medical administration of our in-scope specialty medications. In this tool, contracted medical providers will be able to:

- Verify patient eligibility
- Obtain real-time drug coverage
- Complete any necessary prior authorizations
- Submit claims for reimbursement of medication, level of effort (LOE) and dispensing fee
- Obtain real-time price transparency – both the provider reimbursement amount and member cost share
- Claim reversals can also be completed as necessary using SMAP features

SMAP User Guide – can be found at mspn.linkplatform.com/resources

Payment & Reimbursement

- Contracted medical providers will continue to purchase the in-scope medications from their current preferred source. *This program is NOT a white-bagging effort and does NOT require a contracted provider to purchase the medications from Optum Specialty Pharmacy
- Contracted reimbursement rates are calculated at a fair market rate using either AWP or ASP as determined by MSPN agreement
- Reimbursement rates by NDC are noted on the rate schedule provided in the agreement
- Claims payment will be made as a single claim with a bundled rate covering three components of cost:
 - Medical Specialty Prescription/Medication Drug Contracted Rate by NDC
 - Dispensing fee as a flat fee for ancillary/consumable fixed costs (e.g. gloves, tubing)
 - LOE allowance as a variable rate based on five defined levels of professional effort associated with the infusion as defined in the agreement. Medical Provider must indicate on claim appropriate level for this reimbursement to occur
- Payment to contracted providers will be via check and a paper remittance

Support

- For questions about your network contract, please contact specialty.credentialing@optum.com
- For questions about SMAP or your patient's drug coverage, please call 866-795-7052

XII. Appendix



Appendix A

Independent Pharmacy Credentialing Application




Only complete documents will be accepted.

For Independent Pharmacies

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

Note: Subject to change without notice at any time.

 **OPTUMRX**

Credentiaing Information Required

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

Copies of the following licensee(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!

Credentiaing 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)

Note: Subject to change without notice at any time.

OPTUMRx

OPTUMRx CREDENTIALING APPLICATION and RE-CREDENTIALING FEE

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").

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.

(INSERT COMPANY NAME)

Chain Code/NCPDP # _____

By: _____

(signature)

Name: _____

(print name)

Title: _____

Date: _____

If you have any questions, please contact the OptumRx credentialing department at (800) 613-3391, option 3, or via email at Pharmacycredentialing@optum.com. You may also fax documents to (877) 393-3368.

OptumRx Credentialing Application Fee 12.1.2013

Appendix C

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 the pharmacist is clarifying the submission.	9(2)	T, P, A	

Values

CODE	Description
1	No override
2	Other override
3	Vacation supply
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,
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
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.
19	Split billing
20	340B indicates that prior to providing service, the Network Pharmacy Provider has determined the Drug Product being billed is purchased pursuant 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)).
21	LTC dispensing: 14 days or less not applicable
22	LTC dispensing: 7 days
23	LTC dispensing: 4 days
24	LTC dispensing: 3 days
25	LTC dispensing: 2 days
26	LTC dispensing: 1 day
27	LTC dispensing: 4-3 days
28	LTC dispensing: 2-2-3 days
29	LTC dispensing: daily and 3-day weekend
30	LTC dispensing: Per shift dispensing
31	LTC dispensing: Per med pass dispensing
32	LTC dispensing: PRN on demand
33	LTC dispensing: 7 day or less cycle not otherwise represented
34	LTC dispensing: 14 days dispensing
35	LTC dispensing: 8-14 day dispensing method not listed above
36	LTC dispensing: dispensed outside short cycle
42	Prescriber ID Submitted is valid and prescribing requirements have been validated (value limitation: does not apply to prescriber Medicare enrollment validation)
43	Prescriber's DEA is active with DEA Authorized Prescriptive Right
44	For prescriber ID submitted, associated prescriber DEA recently licensed or re-activated
45	Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule
46	Prescriber's DEA has prescriptive authority for this drug DEA Schedule
47	Other – Shortened Days Supply Fill: Used to request an override to plan limitations when a shortened day supply is being dispensed and a distinct value for the business case has not been defined.
48	Fill Subsequent to a Shortened Days Supply Fill — Used to request an override to plan limitations when a fill subsequent to a shortened days supply is dispensed.
49	Prescriber does not currently have an active Type 1 NPI (value limitation: does not apply to prescriber Medicare enrollment validation)
52	Prescriber's state license with prescriptive authority has been validated
55	Prescriber Enrollment in State Medicaid Program has been validated

56	Pharmacy Enrollment in State Medicaid Program has been validated
57	Discharge Medication
58	Nominal Price
59	Federal Supply Schedule
61	Synchronization Fill – Shortened Days Supply: Used to request an override for shortened days supply to allow the synchronization of dates of service across multiple
62	Shortened Day Supply of Same Drug, Strength and Dosage Form with Multiple NDCs Dispensed: Use to request an override to plan limitations and/or copay benefits when there are multiple claim billing transactions for the same drug and strength due to NDC change(s).
63	Mail Order Delay – Shortened Day Supply: Use to request plan benefit allowances to be applied to the shortened day supply for continuity of care when the mail order fill is in progress.
64	Trial Fill – Shortened Day Supply: Use to request plan benefit allowances to be applied to the shortened day supply for purposes of a trial fill.
65	Individual Patient Emergency RX Fill Request
99	Other

Appendix D

Audit Violations and Discrepancy Descriptions*

NCPDP DATA	ORx Code Description	NCPDP Description	ORx Audit Discrepancy
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 overcharged portion.
1D	RECALCULATE COMPOUND	Compound - Incorrect ingredient product submitted	Recoupment of only overcharged portion.
1E	RECALCULATE COMPOUND	Compound - Incorrect ingredient quantity submitted on one or more ingredients	Recoupment of only overcharged portion.
1F	RECALCULATE COMPOUND	Compound - Ingredient quantities do not equal quantity billed	Recoupment of only overcharged portion.
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 or incomplete date on prescription	Charge back for initial dispensing and refills.
1K	DAW	Incorrect use of Dispense As Written 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

1N	DAYS SUPPLY	Incorrect Days Supply: Submitted Days Supply on Claim is Incorrect	Educational
1P	INVALID DEA or NPI	Missing/invalid prescriber documentation	Full Recoupment
1Q	INVALID RX	Missing/invalid patient documentation	Full Recoupment
1R	WRONG DRUG	Different product/service billed than written on order	Full Recoupment
1S	WRONG DRUG	Different product/service billed than dispensed	Full Recoupment
1T	NDC PACKAGE SIZE	Incorrect Submission: Used smaller size product for larger stock size billed	Educational
1U	INAPPROPRIATE BILLING	Non-covered item billed as covered	Full Recoupment
1V	INAPPROPRIATE BILLING	Non-formulary item	Full Recoupment
1W	DUPLICATE	Duplicate claim billed	Full Recoupment
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
2E	OTHER	Incorrect Other Coverage Code	Partial Recoupment
2F	BILLED APPROPRIATE	No discrepancy adjustment	Educational
2H	OTHER	Other discrepancy not specified	Description in Discrepancy Description Column
2J	WRONG MEMBER	Different patient name on prescription	Full Recoupment

2L	OTHER	Possible clinical issue with gender/age/drug or possible high dose. No documentation to denote clinical appropriateness was validated.	Full Recoupment
2M	WRONG DOCTOR	Submitted prescriber identification is incorrect on claim	Educational
2N	INVALID RX	Doctor signature missing on prescription	Full Recoupment
2P	INVALID RX	No prescriber on prescription order	Full Recoupment
2T	QUANTITY	Quantity dispensed inconsistent with prescriber directions	Partial Recoupment
2U	INVALID RX	Prescription quantity is not complete, no quantity on prescription	Full Recoupment
2V	QUANTITY	Undocumented quantity changed or altered	Full Recoupment
2W	QUANTITY	Billed quantity is different than quantity prescribed	Partial Recoupment
2X	QUANTITY	Invalid quantity billed for single package item	Recoupment dependent on billing
2Y	QUANTITY	No documentation for dispensing a quantity less than prescribed	None; educational for pharmacy only
2Z	REFILL TOO SOON - DAYS SUPPLY ERROR	Refill too soon	Full Recoupment
3A	UNAUTHORIZED REFILL	Unauthorized/Undocumented Refill of Prescription	Full Recoupment
3B	OTHER	Missing/Invalid Risk Evaluation & Mitigation Strategies (REMS) Documentation	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	Prescription does not meet 1 or more of CMS tamper-resistant prescription requirements	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
3J	INVALID RX	Prescription lacks specific, calculable directions (use as directed or missing directions)	Recoupment dependent on billing
3K	DAYS SUPPLY	Exceeds drug program dispensing limits	Partial recoupment
3M	INVALID RX	Diagnosis not documented on prescription	Full Recoupment
3N	INVALID RX	No DEA # on controlled prescription as required by Code of Federal Regulations	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 Patient Attestation Letter (letter indicating patient received and consumed medication)	Full Recoupment
3T	INVALID RX	Missing/Invalid Long Term Care (LTC) Facility Attestation Letter (letter indicating the facility requested/ordered/received the medication)	Full Recoupment
3U	INVALID RX	Missing/Invalid Long Term Care (LTC) Nurse as Prescribers Agent Contract	Full Recoupment
3X	INVALID RX	Missing/Invalid Prescription Label	Full Recoupment
4B	INVALID DEA or NPI	Prescriber ID Not Valid	Full Recoupment for dummy DEA (CII through CV only)
4D	INVALID RX	Unauthorized Changed/Altered Prescription	Full Recoupment

4G	BILL PART B	Billed Medicare incorrectly B vs. D	Full Recoupment
4H	BILLED INAPPROPRIATE COVERAGE	Billed Medicare incorrectly Commercial vs. D	Full Recoupment
4J	INVALID RX	No strength designated on prescription with more than one available strength	Full Recoupment
4K	OTHER	Incorrect Prescription Origin Code	Educational
4L	OTHER	State/Federal Regulation Adherence	Full Recoupment
4M	BILLED INAPPROPRIATE COVERAGE	The claim was billed for an ineligible member	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
4Q	OTHER	Prescription missing overseeing prescriber	Full Recoupment
4R	INVALID RX	Prescription filled before date authorized	Full recoupment if date of service before written date.
4S	OTHER	Prescription illegible -- resubmit documentation	Full Recoupment
4T	INVALID RX	Missing prescription transfer information	Full Recoupment
4U	DAYS SUPPLY	Overbilled quantity	Partial Recoupment
4V	OTHER	Missing/Misused override documentation	Educational
N	BILLED APPROPRIATE	No discrepancy identified	No recoupment

*Audit violations and discrepancy descriptions may differ where cumulative errors rise to a level associated with suspected fraud or abuse as determined solely by Administrator.

Appendix E

Medicaid; CHIP; Federal/State Medicare-Medicaid (MME) enrollees Regulatory and Client-Contractual Program Requirements

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

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

1. Alabama (AL)
 - a. Medicaid Regulatory Requirements
2. Alaska (AK)
 - a. **Medicaid Regulatory Requirements**
3. Arizona (AZ)
 - a. **Acute Medicaid and Chip Downstream Provider (UHC)**
 - b. **Children’s Rehabilitative Services (CRS) State Downstream Provider (UHC)**
 - c. **Long-term-care (LTC) Downstream Provider (UHC)**
 - d. **Medicaid Division of Developmentally Disabled Downstream Provider (UHC)**
 - e. **Pharmacy Services Provided to Community Partnership of Southern Arizona**
4. Arkansas (AR)
 - a. Medicaid Regulatory Requirements
5. California (CA)
 - a. **Medicaid Downstream Provider (UHC)**
 - b. **State Specific Guidelines for Schedule II drugs – Proration of Copay**
 - c. **Medi-Cal Program Regulatory Requirements**
6. Colorado (CO)
 - a. Medicaid Regulatory Requirements
7. Connecticut (CT)
 - a. Medicaid Regulatory Requirements
8. Delaware (DE)
 - a. **State Downstream Provider (UHC)**
9. Florida (FL)
 - a. **Healthy Kids Downstream Provider (UHC)**
 - b. **Long-term-care (LTC) Medicaid Downstream Provider (UHC)**
 - c. Acute/ITN
 - d. Pharmacist to provide Medicaid recipients with the HSA notice/pamphlet when coverage is rejected due to the drug not being on the PDL: Non-preferred drug; Contact provider for change to preferred drug or to obtain prior authorization. Give Medicaid pamphlet if not corrected.
 - e. **Pharmacy Benefit Manager Contract Requirements**
10. Georgia (GA)
 - a. **Medicaid Regulatory Requirements**
11. Hawaii (HI)
 - a. **State Downstream Provider (UHC)**
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. **State Downstream Provider (UHC)**
16. Kansas (KS)
 - a. **Medicaid and CHIP Downstream Provider (UHC)**
17. Kentucky (KY)
 - a. **Medicaid Regulatory Requirements**
18. Louisiana (LA)
 - a. **Medicaid and CHIP Downstream Provider (UHC)**
19. Maine (ME)
 - a. Medicaid Regulatory Requirements
20. Maryland (MD)
 - a. Medicaid Downstream Provider (UHC)
 - b. **Medicaid Addendum**
21. Massachusetts (MA)
 - a. **Government Downstream Provider (UHC)**
 - b. **MME Regulatory Rider**
22. Michigan (MI)
 - a. **State Downstream Provider (UHC)**
23. Minnesota (MN)
 - a. Medicaid Regulatory Requirements
24. Mississippi (MS)
 - a. **MississippiCAN Medicaid Downstream Provider (UHC)**
 - b. **MississippiCHIP Downstream Provider (UHC)**
25. Missouri (MO)
 - a. **Medicaid and CHIP Downstream Provider (UHC)**
26. Montana (MT)
 - a. Medicaid Regulatory Requirements
27. Nebraska (NE)
 - a. **State Downstream Provider (UHC)**
28. Nevada (NV)
 - a. Medicaid Regulatory Requirements
29. New Hampshire (NH)
 - a. Medicaid Regulatory Requirements
30. New Jersey (NJ)
 - a. **Medicaid, Family Care and Medicaid Long Term Support Services Downstream Provider/Subcontractor (UHC)**
31. New Mexico (NM)
 - a. **Centennial Care Downstream Provider (UHC)**
32. New York (NY)
 - a. **Medicaid, Family Health Plus and Child Health Plus Downstream Provider (UHC)**
33. North Carolina (NC)
 - a. **North Carolina State Program Regulatory Requirements Appendix Downstream Provider**
34. North Dakota (ND)
 - a. Medicaid Regulatory Requirements
35. Ohio (OH)
 - a. **State Downstream Provider (UHC)**
 - b. **Medicaid Regulatory Addendum (Catamaran)**
36. Oklahoma (OK)
 - a. **Medicaid Regulatory Requirements**
37. Oregon (OR)
 - a. Medicaid Regulatory Requirements
38. Pennsylvania (PA)
 - a. **Government Downstream Provider (UHC)**

- 39. Puerto Rico
- 40. Rhode Island (RI)
 - a. **Medicaid Downstream Provider (UHC)**
- 41. South Carolina (SC)
 - a. **Medicaid Regulatory Requirements**
 - b. **South Carolina State Program Regulatory Requirements Appendix Downstream Provider**
- 42. South Dakota (SD)
 - a. Medicaid Regulatory Requirements
- 43. Tennessee (TN)
 - a. **TennCare Downstream Provider (UHC)**
 - b. **TennCare Medicaid Regulatory Requirements**
 - c. [TennCare Pharmacy Provider Manual](#)
- 44. Texas (TX)
 - a. **Medicaid and CHIP Downstream Provider (UHC)**
 - b. **TX pharmacy provider manual for UnitedHealthcare Community Plans STAR, STAR+PLUS, STAR Kids and CHIP products**
- 45. Utah (UT)
 - a. Medicaid Regulatory Requirements
- 46. Vermont (VT)
 - a. Medicaid Regulatory Requirements
- 47. Virginia (VA)
 - a. **State Downstream Provider (UHC)**
- 48. Washington (WA)
 - a. **State Downstream Provider (UHC)**
- 49. Washington DC
- 50. West Virginia (WV)
 - a. Medicaid Regulatory Requirements
- 51. Wisconsin (WI)
 - a. Medicaid Regulatory Requirements
- 52. Wyoming (WY)
 - a. Medicaid Regulatory Requirements

Appendix F

MAC State-Specific Requirements

For MAC appeal information, please see MAC appeals contact information provided in Section III of this PM.

Alaska – For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator and must include their acquisition cost from two sources as outlined in the MAC Appeal Submission Guidelines. Administrator will investigate and resolve the MAC Appeal within ten (10) calendar 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 to the lowest acquisition cost submitted by the Provider effective on the day of resolution of the MAC Appeal, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state within the network. Subsequently, Administrator will update MAC reimbursement to the latest applicable referenced acquisition cost effective the date of service plus one calendar day. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC Appeal, 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.

Arkansas — For a pricing reimbursement dispute permitted under Arkansas law, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within thirty (30) business days following the applicable fill date on the Claim. Administrator will investigate and resolve the appeal within thirty (30) business days after the completed MAC Form is received by Administrator. If the appeal is resolved in favor of the Network Pharmacy Provider, Administrator will update the pricing to at least the appealing provider's submitted acquisition cost, 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, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state within the network. Network Pharmacy Provider is required to submit its pharmacy acquisition cost. If Administrator upholds the pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the appeal, identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the price determined by Administrator and provide the name of the referenced national or regional pharmaceutical wholesaler operating in the state. Administrator reserves the right to request supporting documentation to validate drug acquisition cost provided by Network Pharmacy Provider. Network Pharmacy Provider may submit their Invoice Cost information with their appeal submission by emailing MAC@Optum.com. Providers are required to submit with the following information; Email Subject Line: File name and submission date of the appeal. Body of the email: Rx number, fill date, and the NDC number as defined in the MAC Appeal Submission Guidelines.

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 update the MAC, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state within the network no later than one (1) calendar day following the resolution 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 for the denial of the MAC Appeal 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) calendar days from the date of the initial Claim submission.

Administrator will investigate and resolve the MAC Appeal within twenty-one (21) calendar 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 effective no later than one (1) calendar day following the resolution 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 for the denial of the MAC Appeal 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.

Delaware — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) calendar days following the applicable fill date on the Claim, if the reimbursement for the Drug Product is less than the net amount that the Network Pharmacy Provider paid to the supplier of the Drug Product. Administrator will investigate and resolve the MAC Appeal within ten (10) calendar 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 adjust the MAC for the drug as of the date of the original claim for payment without requiring the appealing Network Pharmacy Provider to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with Administrator: a) for the original claim, in the first remittance to the pharmacy after the date the appeal was determined; and b) for subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was determined. In addition, Administrator will for a similarly situated Network Pharmacy Provider contracted in the State: a) adjust the MAC for the drug as of the date the appeal was determined; and b) provide notice to the Network Pharmacy Provider or pharmacy's contracted agent that an appeal has been upheld and without filing a separate appeal, the Network Pharmacy Provider or the pharmacy's contracted agent may request a reversal and reprocessing of a similar claim as outlined in the OptumRx MAC Reverse and Reprocess Request Submission Guidelines available on the OptumRx Provider Portal at <https://professionals.optumrx.com/landing/delaware.html>.

If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC Appeal and identify the NDC of a Drug Product priced at or below the MAC price determined by Administrator from a national or regional wholesaler operating in the state.

Florida – For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within thirty (30) business days after the adjudication of an electronic Claim or reimbursement for a nonelectronic Claim. Administrator will investigate and resolve the MAC Appeal within thirty (30) 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 update the MAC to at least the acquisition cost available to the Network Pharmacy Provider, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, provide to the Network Pharmacy Provider the NDC on which the increase or change is based, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal, identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price below the MAC price determined by Administrator and provide the name of a national or regional wholesaler operating in the state.

Georgia — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within fourteen (14) calendar days following the reimbursement of the initial Claim. Administrator will investigate and resolve the MAC Appeal within fourteen (14) calendar 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, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal 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. The NADAC Period Reports can be accessed by the public from the Optum Rx homepage at <https://www.optumrx.com/public/landing> by clicking on the “Information Center” drop down menu, then clicking on “Forms.” Once redirected to the Forms page, one may access the NADAC Period Reports by expanding the “Other Forms & Reports” banner, then clicking on “Georgia – NADAC Reports.”

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 upon which 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 update the MAC no later than one (1) calendar day following the resolution of the MAC Appeal 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 for the denial of the MAC Appeal 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.

Idaho – For a MAC appeal, the Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within thirty (30) calendar days following the reimbursement of the claim.

Indiana – For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within sixty (60) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within thirty (30) calendar 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 of the drug for the Network Pharmacy Provider that filed the appeal as of the initial date of service that the appealed Claim was dispensed, and adjust the MAC of the drug for all other Network Pharmacy Providers in this state within the network that filled a prescription for patients covered under the same health plan beginning on the initial date of service the appealed drug was dispensed. Administrator will provide notice to all other contracted Network Pharmacy Providers that an appeal has been upheld and will permit the challenging Network Pharmacy Provider and all other Network Pharmacy Providers that filled the prescriptions for patients covered under the same health plan to reverse/resubmit. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC Appeal 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 and provide the name of the referenced national or regional pharmaceutical wholesaler.

Illinois – For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) calendar days from the date of the initial claim submission. Administrator will investigate and resolve the MAC Appeal within fourteen (14) calendar 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 effective on the day of resolution of the MAC Appeal, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal, 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.

Iowa — If the MAC Appeal is resolved in favor of the Network Pharmacy Provider, Administrator will update the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question. Administrator will publish a weekly update to MAC List information online at

<https://professionals.optumrx.com/landing/iowa.html>.

Kansas — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) business days following the applicable fill date on the Claim. 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 update the MAC effective no later than one (1) business day following the resolution of the MAC Appeal, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product that is generally available for purchase by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator from a national or regional wholesalers operating in the state and when applicable, may be substituted lawfully.

Kentucky — For a provider reimbursement Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within sixty (60) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the provider reimbursement within ten (10) calendar 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 and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state within the network. If the non-MAC provider appeal is resolved in favor of the Network Pharmacy Provider, Administrator will adjust the reimbursement for the drug on the original appealed claim for payment without requiring the appealing Network Pharmacy Provider to reverse and rebill the claim. If Administrator upholds the pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the Appeal, identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the reimbursement price determined by Administrator and provide the name of the referenced national or regional pharmaceutical wholesaler operating in the state. Administrator will publish a weekly update to MAC List information online at <https://professionals.optumrx.com/landing/kentucky.html>.

Updates will be posted by end of day Fridays and will reflect prices in effect and/or updated during the previous Thursday through Wednesday, seven-day period.

Louisiana — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fifteen (15) business days following the applicable fill date on the Claim. Administrator will investigate and resolve the MAC Appeal within fifteen (15) 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 update the MAC and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal, 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 the state. Administrator will allow a provider to submit a secondary MAC appeal for a previously denied MAC appeal when the provider is unable to acquire the Administrators referenced product from the Administrators referenced wholesaler at or below MAC. Administrator will review the appeal and update the MAC to at least the appealing provider's submitted acquisition cost and will permit the Network Pharmacy Provider to reverse and rebill the appealed claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged MAC.

Maine — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within fourteen (14) calendar 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, 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 for the denial of the MAC Appeal 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 from a national or regional wholesaler.

Maryland — For a MAC Appeal and Cost Pricing, Network Pharmacy Provider may access OptumRx website at <https://professionals.optumrx.com/resources/manuals-guides/appeals-submission-guide.html> to obtain information about the appeal process. A Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) calendar days from the date of the initial adjudicated claim. Administrator will investigate, resolve the MAC and Cost Pricing Appeal and contact the Network Pharmacy Provider within twenty-one (21) calendar 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 adjust the MAC for the drug as of the date of the original claim for payment without requiring the appealing Network Pharmacy Provider to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with Administrator: a) for the original claim, in the first remittance to the pharmacy after the date the appeal was determined; and b) for subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was determined. In addition, Administrator will for a similarly situated Network Pharmacy Provider contracted in the State: a) adjust the MAC for the drug as of the date the appeal was determined; and b) provide notice to the Network Pharmacy Provider or pharmacy's contracted agent that an appeal has been upheld and without filing a separate appeal, the Network Pharmacy Provider or the pharmacy's contracted agent may reverse and rebill a similar claim.

If the Cost Pricing Appeal is resolved in favor of the Network Pharmacy Provider, Administrator will adjust the reimbursement for the drug on the original appealed claim for payment without requiring the appealing Network Pharmacy Provider to reverse and rebill the claim. In addition, Administrator will provide notice to the appealing pharmacy or pharmacy's contracted agent that an appeal has been upheld.

If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC or Cost Pricing Appeal, 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 or Cost Price and provide the name of the referenced national or regional pharmaceutical wholesaler operating in the state and the mathematical calculation used to determine the MAC or Cost Price. If the Network Pharmacy Provider has any additional questions about the MAC Appeal Process, please contact the MAC Appeal Department as noted on the website or click this [link](#) to view more details.

To ensure the MAC list accurately reflects market pricing and the availability of Generic Drugs, Administrator utilizes multiple sources to determine MAC pricing. The sources are the market pricing benchmark data of AWP and WAC from Medi-span[®]; Cardinal Health[™] and McKesson wholesaler information on pricing and market availability, CMS' NADAC survey of retail acquisition cost, Predictive Acquisition Cost[®] industry analytics, and from pharmacy inquiries and manufactures.

Michigan (Commercial) – For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within forty-five (45) calendar days following the reimbursement of the initial claim. Administrator will investigate and resolve the MAC Appeal within fourteen (14) calendar 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 and 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product that is generally available for purchase at a price at or below the MAC price determined by Administrator.

Michigan (Medicaid) — Administrator will investigate and resolve the MAC Appeal within ten (10) 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 for the denial of the MAC Appeal, and identify three NDCs if there are three or more, and all NDCs if there are fewer than three, of a drug that is available from a Michigan licensed wholesaler. Applicable to Managed Medicaid only.

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 update the MAC effective no later than one (1) business day following the resolution of the MAC Appeal, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal 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.

Mississippi — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within thirty (30) business days following the applicable fill date on the Claim. Administrator will investigate and resolve the MAC Appeal within thirty (30) 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 update the MAC to at least the appealing provider's submitted acquisition cost, 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, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state within the network. Network Pharmacy Provider is required to submit their acquisition cost in order for Administrator to review and grant an Appeal adjustment to at least their acquisition cost. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC Appeal, 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 the state. If the NDC provided by Administrator is not available below the appealing Network Pharmacy Provider's acquisition cost from the pharmaceutical wholesaler from whom the Network Pharmacy Provider purchases the majority of prescription drugs for resale, then upon receipt of notification, Administrator will allow a provider to submit a secondary MAC appeal for a previously denied MAC appeal when the provider is unable to acquire the Administrators referenced product from the Administrators referenced wholesaler at or below MAC. Administrator will review the appeal and update the MAC to at least the appealing provider's submitted acquisition cost and will permit the Network Pharmacy Provider to reverse and rebill the appealed claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged MAC.

Missouri — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) calendar days following the reimbursement of the initial Claim. Administrator will investigate and resolve the MAC Appeal within fourteen (14) calendar 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 effective no later than one (1) calendar day following the resolution of the MAC Appeal, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal 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) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within ten (10) calendar 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 effective on the day of resolution of the MAC Appeal and will permit the challenging Network Pharmacy to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal 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 from a national or regional wholesaler operating in the state.

Nebraska — 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 update the MAC no later than one (1) calendar day following the resolution of the MAC Appeal 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product which may be purchased from a national or regional drug wholesaler by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator. Administrator will publish a weekly update to MAC list information online at <https://professionals.optumrx.com/landing/nebraska-mac-list.html> which will note any price change from the previous list. Network Pharmacy Providers may also obtain this list by emailing MAC@optum.com, or calling the Provider Reimbursement Appeals telephone number at 1-800-613-3591, extension 9. This email address and phone number may also be used to request a print copy of the MAC price list.

New Hampshire — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within thirty (30) business days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within thirty (30) 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 update the MAC no later than thirty (30) business days following the resolution of the MAC Appeal 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 for the denial of the MAC Appeal 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 Jersey — For a provider reimbursement dispute, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the provider reimbursement dispute within fourteen (14) calendar 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 price no later than the day of resolution of the MAC Appeal and will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state within the network.

If the non-MAC provider reimbursement dispute is resolved in favor of the Network Pharmacy Provider, Administrator will adjust the reimbursement for the drug on the original appealed claim for payment without requiring the appealing Network Pharmacy Provider to reverse and rebill the claim.

If Administrator upholds the provider reimbursement pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the provider

reimbursement dispute, 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 the state. Provider reimbursement dispute resolution responses will be sent to the dispensing provider as well as their PSAO, if any.

To ensure the MAC list accurately reflects market pricing and the availability of Generic Drugs, Administrator utilizes multiple sources to determine MAC pricing. The sources are the market pricing benchmark data of AWP and WAC from Medi-span[®]; Cardinal Health[™] and McKesson wholesaler information on pricing and market availability, CMS' NADAC survey of retail acquisition cost, Predictive Acquisition Cost[®] industry analytics, and from pharmacy inquiries and manufactures.

Administrator publishes a weekly report to reflect approved Provider reimbursement disputes resulting in an increase to reimbursement. Reports are available on the OptumRx Provider Portal for 12 weeks. You may access them at [OptumRx New Jersey Provider Information](#).

New Mexico — Network Pharmacy Provider will receive a notice of the reimbursement amount, which will be followed by the payment for the claim. For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) 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 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 update the MAC effective on the day of resolution of the MAC Appeal, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal, 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. If Administrator fails to respond within fourteen (14) business days after receipt of completed MAC appeal submission, Administrator will grant the appeal to the Pharmacy if a Provider Acquisition Cost was submitted at time of appeal. Otherwise, the appeal will be reviewed following the standard process. Provider is required to submit their acquisition cost in order for Administrator to grant an Appeal adjustment to their acquisition cost should the fourteen (14) business day resolution period be exceeded. MAC Appeal resolution responses will be sent to the dispensing provider as well as their PSAO, if any.

Network Pharmacy Provider may access online searchable MAC List Price data, where applicable, as follows:

1. Searchable data is located on the OptumRx Provider Portal at <https://professionals.optumrx.com>.
2. Use your One Healthcare ID to login.
3. Select "Pharmacy e-services: self-service".
4. Navigate to tab "MAC List".
5. Select the time period you are searching.
6. Download report by clicking on your selection.
7. Filter by Health Plan (commercial) client name to see applicable pricing.
8. Filter by Generic Drug Name/Form/Strength or NDC* to see pricing for a specific product.

*NDC indicated represents a single NDC, as an example, for the specified generic product. MAC Value for the indicated NDC also applies to all other generic NDCs for the specified generic drug, form, and strength.

9. MAC Value indicated is applicable to New Mexico Network Pharmacy Providers during the indicated MAC Effective Date and MAC Through Date.

For names of sources used to determine MAC pricing, please refer to Section "Maximum allowable cost (MAC) pricing, review and appeals" of the Provider Manual.

New York — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within thirty (30) calendar 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 update the MAC no later than the day of resolution of the MAC Appeal and will permit the

challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal and identify the NDC of a Therapeutically Equivalent Drug Product that is available for purchase by Network Pharmacy Providers within the state from wholesalers registered pursuant to subdivision four of section sixty-eight hundred eight of the education law at a price at or below the MAC price determined by Administrator.

North Carolina - For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) calendar days following the applicable fill date on the Claim if the reimbursement for the Drug Product is less than the net amount that the Network Pharmacy Provider paid to the supplier of the Drug Product. Administrator will investigate and resolve the MAC Appeal within ten (10) calendar 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 permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal 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 and provide the name of the referenced national or regional wholesaler operating in the state.

Ohio — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within twenty-one (21) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within twenty-one (21) calendar 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 effective no later than one (1) calendar day following the resolution of the MAC Appeal, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal, 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.

Oklahoma — 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 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 update the MAC, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product that is available for purchase by Network Pharmacy Provider below the MAC price determined by Administrator and provide the specific national or regional pharmaceutical wholesaler where the drug is available for purchase. If the Administrator cannot provide a specific national or regional wholesaler where the drug can be purchase by the dispensing pharmacy below the MAC price determined by Administrator, the Administrator shall immediately adjust the reimbursement amount, permit the pharmacy to reverse and rebill the claim in question and make the reimbursement amount adjustment retroactive and effective for all contracted providers.

Oregon — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within sixty (60) calendar days following the reimbursement of the initial 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 adjust the MAC for the drug as of the date of the original claim for payment, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state within the network. Administrator will reprocess and adjust reimbursement for the claim in question without charging any adjudication fees. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC Appeal 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.

Pennsylvania — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within fourteen (14) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC appeal within fourteen (14) calendar 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 from the date of the approved 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider.

Rhode Island — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within fifteen (15) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within fifteen (15) calendar 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 effective no later than one (1) calendar day following the resolution 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 for the denial of the MAC Appeal 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.

South Carolina — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete, and submit the MAC Form to Administrator within ten (10) calendar days following the applicable fill date on the Claim if the reimbursement for the Drug Product is less than the net amount that the Network Pharmacy Provider paid to the supplier of the Drug Product. Administrator will investigate and resolve the MAC Appeal within ten (10) calendar 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 permit the challenge Network Pharmacy Provider reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal 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 and provide the name of the referenced national or regional wholesaler operating in the state.

Tennessee — Consistent with T.C.A. § 56-7-3206(c)(2)(B)(ii) and TN Rule 0780-01-95-.05, OptumRx's MAC appeals process may be used for non-MAC related reimbursement appeals, and all prescription drugs or devices for which a provider alleges it did not receive its actual cost. Providers must file appeals within seven (7) business days of its submission of the initial claim. Administrator will investigate and resolve the appeal within seven (7) business days after receipt of the completed MAC Appeal Submission Template, or the Tennessee Standard Pharmacy Reimbursement Appeal Form. The timeline for final determination of the initial appeal will begin once Administrator has received all of the required information including: 1) a complete version of the OptumRx MAC Appeal Submission Template or Tennessee Standard Pharmacy Reimbursement Appeal Form; and 2) certification from the Provider that it has provided all invoices or other records demonstrating the Provider's actual costs for the drug or medical product or device at issue, including all discounts, price concessions, rebates or other reductions received as of the date that the Provider filed its appeal. If a Provider's appeal does not contain all information required under TN Rule 0780-01095-.05(2), Administrator will accept the incomplete appeal and

hold it open pending receipt of additional information from Provider. Within five (5) business days of receipt of an incomplete appeal, Administrator will notify Provider of the information needed to complete Administrator's review the appeal. If the Provider provides the requested information, within five (5) business days of receipt of the Administrator's notice outlining the requested information, Administrator's timeline to make final determination shall start. If the Provider fails to provide the requested information within five (5) business days of receipt of Administrator's notice, Administrator will deny Provider's appeal. If Administrator fails to comply with the timing and notice requirements under applicable law, the appeal shall be resolved in favor of the Provider.

Tennessee providers are required to include pharmacy acquisition cost with their appeal submission as outlined below. If a Provider is using Optum Rx's MAC Appeal Submission Template to submit an appeal, please complete the template and enter acquisition cost information into Column "K". If the required provider acquisition cost information is not submitted at time of appeal, OptumRx will be unable to review and resolve the appeal and will request resubmission of the appeal with the required information for reprocessing, as more fully described above. Tennessee providers are required to include name of wholesaler or manufacturer, as applicable, from which the pharmacy purchased the drug or medical product or device at issue, please place that information in the Column "J" under Notes. A copy of the Provider's invoice demonstrating the pharmacies actual cost as of the date of the filing can be emailed to MAC@optum.com.

Texas (Medicaid) — Administrator will investigate and resolve the MAC Appeal within fifteen (15) calendar 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 effective on the day of resolution of the MAC Appeal, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal.

Texas (Commercial) — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within ten (10) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within ten (10) calendar 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 (1) calendar day following the resolution of the MAC Appeal., will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product that is generally available for purchase by Network Pharmacy Provider within the state at a price at or below the MAC price determined by Administrator from a national or regional wholesaler.

Utah — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) calendar 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 for the denial of the MAC Appeal 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) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within ten (10) calendar days after the completed MAC Form is received by Administrator.

Administrator shall allow Network Pharmacy Provider to submit a MAC appeal after the ten (10) calendar day period if the claim is subject to an audit by Administrator. Network Pharmacy Provider must submit the MAC Form within ten (10) calendar days from the date following notification of final audit findings. If the MAC appeal is resolved in favor of the Network Pharmacy Provider, Administrator will make the change in

the MAC within 30 business days after the redetermination 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product that is generally available for purchase 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.

Virginia — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within fourteen (14) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within fourteen (14) calendar 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 five (5) calendar days following the resolution 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 for the denial of the MAC Appeal 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 for review. Administrator will investigate and resolve the MAC Appeal within thirty (30) calendar days after the completed MAC Form is received by Administrator. Administrator will uphold the appeal of a network pharmacy with fewer than fifteen retail outlets within the state of Washington, under its corporate umbrella, if the pharmacy demonstrates that they are unable to purchase therapeutically equivalent interchangeable product from a supplier doing business in the state of Washington at the pharmacy benefit manager's list price. Network Pharmacy Provider is required to submit acquisition cost. If the MAC Appeal is resolved in favor of the Network Pharmacy Provider, Administrator will make a reasonable adjustment on a date no later than one day after the date of determination and will issue an adjustment on the claim in question in the next remittance period. If Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC Appeal and identify the NDC of a Drug Product that has been purchased by a Network Pharmacy Provider within the state at a price at or below the MAC price determined by Administrator. Qualifying Network Pharmacy Providers may be eligible to file brief adjudicative proceedings following a denial from Administrator. Any such request must be timely made with the Washington Office of Insurance Commissioner no later than thirty (30) calendar days of receiving Administrator's decision. If an appeal concerns a non-MAC reimbursed Claim based on applicable contracted rates, you will need to submit your appeal to the Pharmacy Provider Relations Department by utilizing our Claim Review Inquiry page on our Intake Form: [Pharmacy Provider Relations Intake Form \(optumrx.com\)](#).

West Virginia – The NADAC Quarterly Reports can be accessed by the public from the Optum Rx homepage <https://www.optumrx.com/public/landing> by clicking on the “Information Center” drop down menu, then clicking on “Forms.” Once redirected to the Forms page, one may access the NADAC Period Reports by expanding the “Other Forms & Reports” banner, then clicking on “West Virginia – NADAC Reports.”

Wisconsin — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) calendar days from the date of the initial Claim submission. Administrator will investigate and resolve the MAC Appeal within twenty-one (21) calendar 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 (1) calendar day following the resolution 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 for the denial of the MAC Appeal 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.

Wyoming — For a MAC Appeal, Network Pharmacy Provider must obtain, fully complete and submit the MAC

Form to Administrator within ten (10) business days following the applicable fill date on the Claim. 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 update the MAC no later than one (1) calendar day following the resolution of the MAC Appeal, will permit the challenging Network Pharmacy Provider to reverse/rebill the Claim in question, as well as make the adjustment applicable to all similarly situated Network Pharmacy Providers in this state 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 for the denial of the MAC Appeal and identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider within the state and the name of a national or regional pharmaceutical wholesaler that has the Drug Product available for purchase at a price at or below the MAC price determined by Administrator from a national or regional wholesalers.

Appendix G

Client-Specific Information

Arizona Health Care Cost Containment System (AHCCCS)

The Contractor, its contracted Pharmacy Benefit Manager (PBM), and the PBM's Pharmacy Network shall comply with the following:

1. Under the AHCCCS program, pharmacies shall not charge patients the cash price for a prescription other than an applicable copayment when the medication is federally and state reimbursable and the prescription is ordered by an AHCCCS Registered Prescribing Clinician.
2. Pharmacies shall not split bill the cost of a prescription claim to the Contractor's PBM for a patient under the AHCCCS Program. The Contractor's PBM's Pharmacy Network shall not allow a patient under the AHCCCS Program to pay cash for a partial prescription quantity for a federally and state reimbursable medication when the ordered drug is written by an AHCCCS Registered Prescribing Clinician.
3. Pharmacies are prohibited from auto-filling prescription medications.
4. Pharmacies shall not submit prescription claims to the contracted PBM for claims adjudication requesting reimbursement in excess of the Usual & Customary (U&C) price charged to the general public.
 - a. The sum of charges for the submitted ingredient cost plus the dispensing fee shall not exceed a pharmacy's U&C Price for the same prescription.
 - b. The U&C submitted ingredient cost shall be the lowest amount accepted from any Member of the general public who participates in the pharmacy provider's savings or discount programs including programs that require the Member to enroll or pay a fee to join the program.
5. Pharmacies that purchase drugs at a nominal Price outside of 340B or the Federal Supply Schedule shall bill their Actual Acquisition Cost of the drug to AHCCCS and the Contractor's PBM and PBM network pharmacies, at the discretion of the pharmacy, may deliver or mail prescription medications to an AHCCCS Member or to an AHCCCS registered provider's office for a specific AHCCCS Member.

FedEx

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 following Reason for Service and Result of Service codes are used specifically for FedEx members.

Override Codes for Pharmacy			
Description	Reason for Service Code	Professional Service Code	Result of Service Code
<u>Drug-Diagnosis Caution</u>	MC =	M0 = Prescriber Consulted	1A = Filled as is, false positive

Screening: Checks the member's health profile record for conflict between listed diagnosis and the incoming claim	Drug-Disease Reported		1B = Filled prescription as is
			1G = Filled with prescriber approval
		R0 = Pharmacist Consulted Other Source	1A = Filled as is, false positive
			1B = Filled prescription as is
Drug-Inferred Health State Screening: Infers a health state and determines if the submitted drug or profile drug conflicts with that health state	DC = Drug-Disease Inferred	M0 = Prescriber Consulted	1A = Filled as is, false positive
			1B = Filled prescription as is
			1G = Filled with prescriber approval
		R0 = Pharmacist Consulted Other Source	1A = Filled as is, false positive
			1B = Filled prescription as is
Drug-Age Screening: Identifies contraindication based on the member's age	PA = Drug-Age	M0 = Prescriber Consulted	1A = Filled as is, false positive
			1B = Filled prescription as is
			1G = Filled with prescriber approval
		R0 = Pharmacist Consulted Other Source	1A = Filled as is, false positive
			1B = Filled prescription as is
Drug-Sex Caution Screening: Identifies contraindications based on the member's gender and incoming claim	SX = Drug-Gender	M0 = Prescriber Consulted	1A = Filled as is, false positive
			1B = Filled prescription as is
			1G = Filled with prescriber approval
		R0 = Pharmacist Consulted Other Source	1A = Filled as is, false positive
			1B = Filled prescription as is
Duplicate Therapy Screening: Checks for potential therapeutic or ingredient duplications based on duplicate therapy classes	TD = Therapeutic	M0 = Prescriber Consulted	1A = Filled as is, false positive
			1B = Filled prescription as is
			1G = Filled with prescriber approval
		R0 = Pharmacist Consulted Other Source	1A = Filled as is, false positive
			1B = Filled prescription as is
Dosing-Duration Screening: Compares the dosage on the incoming claim to the recommended dosage for the member's age group	HD = High Dose	M0 = Prescriber Consulted	1A = Filled as is, false positive
			1B = Filled prescription as is
			1G = Filled with prescriber approval
		R0 = Pharmacist Consulted Other Source	1A = Filled as is, false positive
			1B = Filled prescription as is
Drug-Drug Interaction: Checks the member's prescription history for interactions between two or more drugs	DD = Drug-Drug Interaction	M0 = Prescriber Consulted	1A = Filled as is, false positive
			1B = Filled prescription as is
			1G = Filled with prescriber approval
		R0 = Pharmacist Consulted Other Source	1A = Filled as is, false positive
			1B = Filled prescription as is

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

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 [NCPDP Online](#).

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.

Louisiana Fee-for-Service (FFS) Medicaid 340B Billing Policy

The Louisiana Department of Health (LDH) FFS Pharmacy Program has updated their 340B billing policy at point-of-sale (POS). Providers who are designated as a "Covered Entity," and have opted to "Carve-In" (all drugs dispensed to Medicaid patients and purchased under the 340B Drug Pricing Program) should review the following guidelines in the letter (located at the link below).

[FFS 340B Billing Updated signed 7-29-19.pdf \(lamedicaid.com\)](#)

State of HI Community & State

United HealthCare Community & State plan of Hawaii requires a Place of Service Code when submitting a prescription. The Place of Service Code is also known as NCPDP field number 307-C7. A list of codes and description crosswalk can be found below. Claims that do not include an appropriate Place of Service Code will reject with a message of 12-M/I Place of Service.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective October 1, 2003)

02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022.)
03	School	A facility whose primary purpose is education. (Effective January 1, 2003)
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (Effective January 1, 2003)
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (Effective January 1, 2003)
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (Effective January 1, 2003)
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. (Effective January 1, 2003)
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (Effective January 1, 2003)
09	Prison/ Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective July 1, 2006)
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. (This code is effective January 1, 2022, and available to Medicare April 1, 2022.)
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective October 1, 2003)

14	Group Home *	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). (Effective October 1, 2003)
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. (Effective January 1, 2003)
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective January 1, 2008)
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)
18	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013)
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective January 1, 2003)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the

		level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (Effective October 1, 2003)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (Effective October 1, 2003)
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT). (Effective January 1, 2020)
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

**State of NJ Community & State
Pharmaceutical Services:**

1. Pharmacies shall keep and maintain wholesaler, manufacturer, and distributor invoices and other

purchase invoices and documents for prescription drugs and medical supplies for a minimum of ten (10) years. Purchase records must indicate price, drug name, dosage form, strength, NDC, lot number and quantity. Pharmacies shall also maintain adequate records to validate purchases from wholesalers including but not limited to canceled check information. Pharmacies must promptly comply with any requests to produce such documentation to DMAHS and/or MFD.

2. Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy - Verified Accredited Wholesaler Distributors (NABPVAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.
3. Pharmacies are required to have a product in stock at the pharmacy prior to submitting a claim for the product. All claims' submissions shall contain the National Drug Code (NDC) of the product dispensed. Only the NDC of the actual product dispensed shall be submitted on the claim. Use of a similar NDC of a product not dispensed is not permissible.
4. Pharmacies shall keep and maintain any compound recipe worksheets identifying ingredients used in a compounded prescription drug. Pharmacies must submit claims with all ingredients included in each compound and may only submit claims with the NDC associated with the actual ingredients filled/dispensed. Pharmacies must promptly comply with any requests to produce such electronic or paper documentation to the Medicaid/NJ FamilyCare program and/or its agents.
5. Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and non-legend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer's name, address, and registration number.

State of WA Community & State

The Contractor, its contracted Pharmacy Benefit Manager (PBM), and the PBM's Pharmacy Network shall comply with the following:

1. Under the State of WA Community & State program, pharmacies shall not charge patients the cash price for a prescription other than an applicable copayment when the medication is federally and state reimbursable and the prescription is ordered by an WA Registered Prescribing Clinician.
2. Pharmacies shall not split bill the cost of a prescription claim to the Contractor's PBM for a patient under the State of WA Community & State Program. The Contractor's PBM's Pharmacy Network shall not allow a patient under the State of WA Community & State Program to pay cash for a partial prescription quantity for a federally and state reimbursable medication when the ordered drug is written by an WA Registered Prescribing Clinician.
3. Pharmacies are prohibited from auto-filling prescription medications.
4. Pharmacies shall not submit prescription claims to the contracted PBM for claims adjudication requesting reimbursement in excess of the Usual & Customary (U&C) price charged to the general public.
 - a. The sum of charges for the submitted ingredient cost plus the dispensing fee shall not exceed a pharmacy's U&C Price for the same prescription.
 - b. The U&C submitted ingredient cost shall be the lowest amount accepted from any Member of the general public who participates in the pharmacy provider's savings or discount programs including programs that require the Member to enroll or pay a fee to join the program.

5. Pharmacies that purchase drugs at a nominal Price outside of 340B or the Federal Supply Schedule shall bill their Actual Acquisition Cost of the drug to State of WA Community & State and the Contractor's PBM and PBM network pharmacies, at the discretion of the pharmacy, may deliver or mail prescription medications to an State of WA Community & State Member or to an State of WA Community & State registered provider's office for a specific State of WA Community & State Member.
6. For an Appeal, the PBM network pharmacy must obtain, fully complete and submit the Form to the PBM for review. The PBM will investigate and resolve the Appeal within thirty (30) calendar days after the completed Form is received by the PBM. The PBM will uphold the appeal of a network pharmacy with fewer than fifteen retail outlets within the state of Washington, under its corporate umbrella, if the pharmacy demonstrates that they are unable to purchase therapeutically equivalent interchangeable product from a supplier doing business in the state of Washington at the pharmacy benefit manager's list price. The PBM network pharmacy is required to submit acquisition cost. If the Appeal is resolved in favor of the PBM network pharmacy, the PBM will make a reasonable adjustment on a date no later than one day after the date of determination and will issue an adjustment on the claim in question in the next remittance period. If the PBM upholds the Pricing of the particular Covered Prescription Service Drug Product at issue, the PBM shall provide the PBM network pharmacy the reason for the denial of the Appeal and identify the NDC of a Drug Product that has been purchased by a PBM network pharmacy within the state at a price at or below the price determined by the PBM. Qualifying PBM network pharmacies may be eligible to file brief adjudicative proceedings following a denial from the PBM. Any such request must be timely made with the Washington Health Care Authority no later than thirty (30) calendar days of receiving the PBM's decision.

TennCare

The TennCare Pharmacy Manual supersedes the OptumRx Provider Manual. The TennCare Pharmacy Manual is located at this link [Pharmacist \(optumrx.com\)](https://www.optumrx.com) _

YourCare Health Plan – New York Client and State Specific Prescription Pad Serial Number Requirements

In pursuant to the New York State guidelines, pharmacy providers processing claims for YourCare Health Plan Members [in the state of New York] must include the prescription (Rx) pad serial number. The Rx pad serial number is referenced on the actual Rx.

The table below shows which prescription (Rx) pad serial numbers are allowed for each origin code. Please ensure your pharmacy includes the correct serial numbers for the corresponding origin code. This will avoid unnecessary rejections to the patient's claims.

Origin Code	Corresponding Serial	Description
1	Unique ONYSRx #	Written - Prescriptions prescribed in NY will be on Official New York Prescription forms with a designated serial number to use.
1	ZZZZZZZZ	Written - Prescriptions prescribed from out-of-state providers or by prescribers within a federal institution (e.g. US Department of Veteran Affairs) or Indian Reservation.
2	99999999	Telephone - Prescriptions obtained via oral instructions or interactive voice response using a telephone.
2	SSSSSSSS	Telephone - Fiscal orders obtained via oral instructions using a telephone. *
3	EEEEEEEE	Electronic - Prescriptions obtained via SCRIPT or HL7 standard transactions, or electronically within closed systems. **
4	Unique ONYSRx #	Facsimile - ONYSRx Prescriptions obtained via fax machine transmission.
4	SSSSSSSS	Facsimile - Fiscal Orders not on a ONYSRx obtained via fax machine transmission.

		*
4	NNNNNNNN	Facsimile - Prescriptions obtained via fax machine transmission for nursing home patients (excluding controlled substances) in accordance with written procedures approved by the medical or other authorized board of the facility.
5	TTTTTTTT	Pharmacy - this value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as transitional transfers, intro-chain transfers, file buys, software upgrades/migration, and any reason necessary to give it a new number. ***
5	99999999	Pharmacy - this value is appropriate for “Pharmacy dispensing” when applicable such as non-patient specific order, BTC (behind the counter), Plan B, established protocols, etc.
5	DDDDDDDD	Pharmacy - this value is used to cover prescriptions dispensed as Medically Necessary during a Declared State of Emergency (excluding controlled substances).

REMINDERS

A designated unique ONYSRx number for written prescriptions prescribed by the New York in-state providers must be included. If a prescription is received from an out-of-state provider or via telephone, confirm the correct default Rx serial pad number.

- Origin Code = 1, enter: ZZZZZZZZ (out of state)
- Origin Code = 2, enter: 99999999 (telephonic)
- Origin Code = 3, enter: EEEEEEEE (electronic)
- Origin Code = 5:
 - When new Rx number needs to be created from an existing valid prescription, enter: TTTTTTTT
 - For Pharmacy Dispensing, enter: 99999999
 - For prescriptions dispensed as Medically Necessary during a Declared State of Emergency, enter: DDDDDDDD

This notice only applies to YourCare Health Plan.

UnitedHealthcare

United Healthcare Community & State Specific

If you wish further review on a claim that Administrator responded with “Paid at NADAC” on appeal, you may further contact Pharmacy Provider Relations department via our Intake Form at: [Pharmacy Provider Relations Intake Form \(optumrx.com\)](#).

NADAC pricing benchmark is reported and maintained by CMS. See [National Average Drug Acquisition Cost \(medicaid.gov\)](#) for further information, or contact the NADAC help desk facilitated by Myers and Stauffer at:

Toll-free phone: (855) 457-5264
 Email: info@mnlcrps.com
 Fax: (844) 860-0236

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
- If the pharmacy is part of OptumRx’s Medicare Advantage pharmacy networks, they may be contracted for Part D and B services.
 - OptumRx allows some Part B covered drugs or supplies to be submitted through their claims processing system and these will adjudicate under the Part B benefit. The pharmacy should refer to sections B. Medicare Part A/B/D coordination of benefits (COB) and V. Claim Notification - Dual Eligible Members and Part B Drugs for Part B claims questions.
 - When a Member has qualifying Medicaid coverage (reference Medicaid Qualifying Coverage grid below), the Part B cost share must be billed to Medicaid. Some Medicaid programs do not allow electronic secondary billing or automatic crossover when the claim is processed through the Medicare Advantage Plan.
 - Contact Medicaid to ask how to appropriately bill the Medicare Cost-Sharing Amount when the Member is enrolled in a Medicare Advantage Plan and has qualifying Medicaid coverage.

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 (Louisiana Bayou Health): 1-866-328-3108
- 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	UHCACIS0		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 650540 Dallas, TX 752650540	P.O. Box 650540 Dallas, TX 752650540	P.O. Box 650540 Dallas, TX 752650540	P.O. Box 650540 Dallas, TX 752650540
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Changes to this year's Medicare Part D Formulary, for the following Benefit Plans, will be posted on the websites listed below.

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

Plan	Website
AARP MedicareComplete AARP MedicareRx Enhanced AARP MedicareRx	https://aarpmedicareplans.com/medicare-education.html
Erickson Advantage	ericksonadvantage.com
IBT (International Brotherhood of Teamsters)	teamstarpard.com
Golden State Medicare Health Plan	goldenstatemhp.com or gsmhp.com
PSERS (Pennsylvania Public School Educators' Retirement System)	hopbenefits.com
Sierra MAPD Plan	sierrahealthandlife.com
UnitedHealthcare Community Plan	uhccommunityplan.com

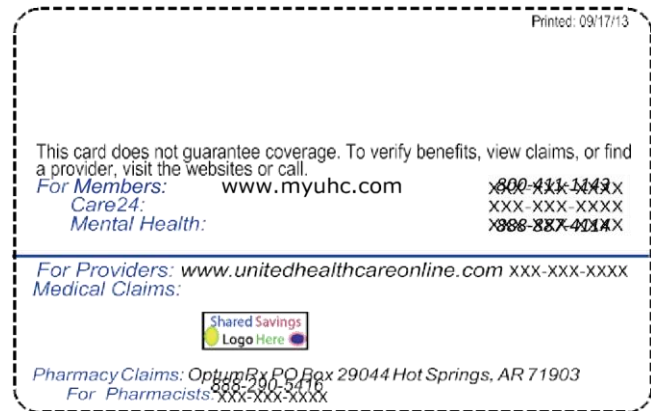
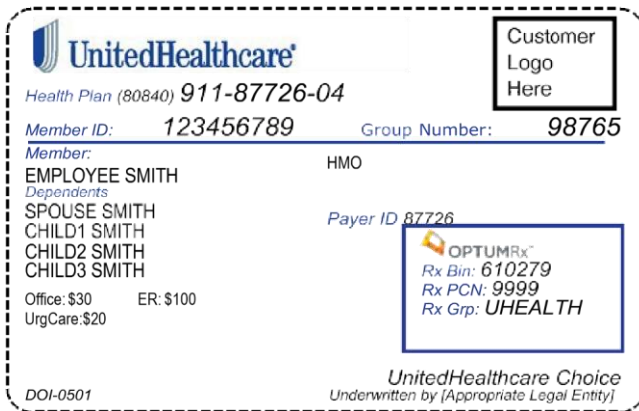
Troubleshoot Member ID Cards

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</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>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;</p>
	<p>access E1, move to step 2 Note: An E1 transaction can be initiated with the Member's Social Security Number (SSN) or Member's ID.</p>	<p>(b) Unable to validate eligibility, move to step 3.</p>		<p>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 (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 III of this PM.</p> <p>(a) Pharmacy Help Desk validates eligibility and claim is processed (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>
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UnitedHealthcare Sample Member ID Cards



Local Pick-Up Program

If the Network Pharmacy Provider participates in the 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 Administrator. 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 the participating Network Pharmacy Providers; signing and returning to Administrator the packing slip confirming receipt of the order; storing the Prescription orders in a designated location; handing Prescription orders to eligible Members or Member's appointed/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 or for all Clients and may vary state-by-state in accordance with applicable state laws.

Appendix H

Commercial Requirements

Additional state-specific exhibits set forth certain requirements that Network Pharmacy Providers shall comply with, as applicable.

Colorado State Fully Insured and Non-ERISA ASO Business

- Neither the carrier nor Network Pharmacy Provider are prohibited from expressing disagreement with a medical decision, medical policy, or medical practice of the other. In addition, retaliatory action is prohibited for such decision or practice.
- Carrier may not take an adverse action against a Network Pharmacy Provider because the Network Pharmacy Provider, acting in good faith:
 - Communicates with a public official or other person concerning public policy issues related to health care items or services;
 - Files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of the carrier the Network Pharmacy Provider believes might negatively affect the quality of, or access to, patient care;
 - Provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of this section;
 - Reports what the Network Pharmacy Provider believes to be a violation of law to an appropriate authority; or
 - Participates in any investigation into a violation or possible violation of any provision of this section.

Tennessee State Commercial Fully-Insured

- Any material changes to the OptumRx Provider Manual will not take effect until 60 days following notification.

Washington State Commercial Fully-Insured

- In every Network Pharmacy Provider agreement, every issuer will state that an issuer will authorize an emergency fill by the dispensing Pharmacist and approve the Claim payment. An emergency fill is only applicable when:
 - The dispensing Network Pharmacy Provider cannot reach the issuer's Prior Authorization department by phone, as it is outside of that department's business hours; or
 - An issuer is available to respond to phone calls from a dispensing Network Pharmacy Provider regarding a covered benefit, but the issuer cannot reach the Prescriber for full consultation.
- Network Pharmacy Providers and issuers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

Click the appropriate addendum link(s) to access state-specific regulatory requirements listed below.

1. Colorado (CO) Regulatory Addendum
2. Maryland (MD) Regulatory Addendum
3. Massachusetts (MA) UHC Regulatory Addendum

optum.com/optumrx

11000 Optum Circle, Eden Prairie, MN 55344

OptumRx is a pharmacy care services company helping clients and more than 65 million members achieve better health outcomes and lower overall costs through innovative prescription drug benefits services, including network claims processing, clinical programs, formulary management and specialty pharmacy care. OptumRx is part of Optum[®], a leading information and technology-enabled health services business dedicated to making the health system work better for everyone. For more information, visit optum.com/optumrx.



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