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Provider Portal

Supplemental Policies, Procedures and Regulations

Prepared by:

EnvisionRx

800-361-4542

WWW.ENVISIONRX.COM

This document contains detailed explanations of certain conditions of participation in the EnvisionRx Pharmacy Network. Procedures are outlined for the electronic submission of Pharmacy Claims. Also contained are helpful contact numbers, payment terms, answers to common questions and our pricing and reimbursement process.

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Advertising Requests

Pharmacy providers are expressly denied any rights to use the EnvisionRx name, likeness, logo or other forms of advertisement without prior, written consent from EnvisionRx. This applies to all advertisements that reference EnvisionRx in any way regardless of the advertising medium. To request permission, submit a copy of the advertisement if printed medium or script, if radio, TV, or cable, via fax to Provider Relations at 330-405-8094. In the request, the Pharmacy provider must include the Pharmacy contact name and telephone number, reason for the advertisement, duration and market(s) where the advertisement will be placed. Approval or denial by EnvisionRx will be communicated in writing to the requesting Pharmacy once internal review is completed. Note that any advertising designed to waive or discount participant Cost Share (copayments, coinsurances or deductibles) will automatically not be approved.

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GENERAL INFORMATION

This Provider Portal of our Policies, Procedures and Regulations is designed to offer you, our participating Pharmacy providers, with important information regarding our program requirements and our operational procedures. Participating Pharmacy providers that sign our Participating Provider Agreement (PPA) are contractually bound to comply with the terms of these Policies, Procedures and Regulations.

As a participating Pharmacy provider, you will receive a fully signed PPA. If your Pharmacy has not received its copy of the PPA, or if you have any questions regarding the PPA, please call our Pharmacy Help Desk at 800-361-4542 (TTY Users may call 711). All Pharmacies are expected to adhere to the PPA terms. Failure to comply could result in the termination of your PPA by EnvisionRx.

EnvisionRx credentials potential Pharmacy providers prior to their acceptance in any EnvisionRx Network. EnvisionRx monitors the credentials of its providers in accordance with EnvisionRx policies, acceptable industry standards and/or as mandated by law. Pharmacy providers must respond promptly to provide EnvisionRx with any requested documentation necessary to in order to maintain its participation status.

Any updates to your Pharmacy's mailing or location address, telephone number, payment addresses etc., must be submitted to NCPDP for any Pharmacy update submissions.

EnvisionRx reserves the right to update this document from time to time. The latest copy of the Provider Portal can be found at www.envisionrx.com under Provider.

CONTACT INFORMATION / WHERE TO GET HELP

The Pharmacy Help Desk is available 24 hours a day, 7 days a week, 365 days per year including holidays, at: 800-361-4542 (TTY Users may call 711). The Pharmacy Help Desk is available to assist with billing/payment inquiries, Claims and formulary questions, disputes and appeals, Member/plan benefits, Member eligibility, Pharmacy Network issues, and prior authorizations. If a Pharmacy has suggestions as to how the Network can better serve our Members, they can contact the Pharmacy Help Desk as well.

- If a Member has a general or clinical question or a dispute regarding a Claim, please refer them to our Customer Service number located on the reverse side of their membership card. Members in the program should be directed to call the number on the back of their card (TTY Users may call 711).

- If your Pharmacy has a question regarding an accounting issue such as payments, EFT set up, etc., send an email to EnvisionRx at pharmacyaccountingissues@envisionrx.com

- If your Pharmacy has a question regarding MAC drug pricing, email EnvisionRx at MAC@envisionrx.com

Other Important Phone Numbers

Department	Phone Number
Report Fraud Waste & Abuse	(866) 417-3069
Dispute Resolution	(800) 361-4542
Coverage Determinations	(800) 361-4542

NETWORK APPLICATION AND CREDENTIALING GUIDELINES

Applying for Participation

To apply to become a participating Pharmacy, the applicant can fill out the online new participating Pharmacy enrollment application at: https://www.envisionrx.com/PrescribersAndProviders/Pharmacies#IndependentPharmacyEnrollment or call the Pharmacy Help Desk at 800-361-4542 (TTY Users may call 711). Once the application is submitted, EnvisionRx will initiate the enrollment process. Please allow up to 45 business days to process credentials in order to add your Pharmacy to the EnvisionRx Network(s).

Credentialing Guidelines

EnvisionRx initially credentials and continually monitors the credentials of all participating Pharmacy providers prior to and after inclusion in EnvisionRx Networks. Providers are required to meet various conditions of participation as set forth by EnvisionRx and to adhere to governmental regulations and standards, as applicable. The Credentialing process includes a review of the following:

1. Independent Pharmacies/Dispensing Providers must have:
    - Current DEA
    - Current State License
    - Current Professional Liability Insurance at required levels
    - No sanctions per the Office of Inspector General, Health and Human Services (HHS)
    - No sanctions per any Office of Medicaid Inspector General in any state
    - No sanctions per the System for Award Management (SAM) and Medicare Exclusion Databases (MED)
    - Clear Pharmacy Board Orders
    - Additional information as determined by EnvisionRx

2. PSAO/Chain Pharmacies must attest to (and be able to provide annually):
    - Verification of Credentialing program for itself and each of its member pharmacies
    - Copy of Credentialing policy for itself and each of its member pharmacies
    - Current DEA
    - Current State License
    - OIG and SAM Exclusion of Pharmacy
    - Current Professional Liability Insurance Certificate

- If PSAO does not attest, each Pharmacy will be recognized as an Independent Pharmacy and will adhere to the same Credentialing standards as an Independent (see above for Independent Credentialing Standards)

EnvisionRx uses primary-source verification during its review of the Pharmacy license and DEA registration.

Quarterly Provider Credentialing Audits

EnvisionRx audits the credentials of its participating providers on a quarterly basis. We may contact your Pharmacy to request proof of insurance coverage or additional copies of your Pharmacy's other credentials. The required documents will need to be faxed or emailed the same business day of the request, unless another timeframe is noted in your PPA with EnvisionRx.

If your Pharmacy is contacted during an EnvisionRx quarterly Credentialing check, we thank you for your anticipated cooperation in gathering and submitting the Credentialing information we may require.

NETWORK PHARMACY CONTRACTING

EnvisionRx shall enter into a PPA, amendment, or addendum to a current PPA when contracting with a new Chain, PSAO, or Independent Pharmacy to become a participating Pharmacy in the EnvisionRx Network, or when renegotiating an existing contract (e.g. changes in fee schedules or contracting provisions) with a current participating Pharmacy. In addition, PPAs entered into with Medicare Network Pharmacies shall comply with all CMS requirements and instructions.

NON-PREFERRED VS. PREFERRED STATUS

Providers who currently have "preferred" status in an EnvisionRx Network may lose that status if they join a PSAO that does not have a "preferred" status in its contract with EnvisionRx.

PROVIDER AND MEMBER SERVICE STANDARDS

NON-DISCRIMINATION CLAUSE

EnvisionRx participating Pharmacy providers shall not discriminate against Members with respect to a person's age, gender, race, disability, ethnic group, national origin, or making a distinction in favor of or against, a person or thing based on the group, class or category to which that person or thing belongs rather than on individual merit. Additionally, providers shall not discriminate against Members as it relates to health care such as accepting only Members from within a product line based upon high reimbursement rate and excluding other Members within that same product line based upon lower reimbursement rate.

PROVIDER NETWORK - ACCESSIBILITY

EnvisionRx participating Pharmacy providers shall ensure that Members receive equal treatment, access, and rights without regard to race, color, national origin or Limited English Proficiency (LEP). Providers shall provide or arrange language assistance (i.e. interpreters and/or language appropriate written materials) to person with LEP. All Pharmacies in EnvisionRx Networks must be compliant with applicable access standards related to the Americans with Disabilities Act of 1990 (or its successor).

PROVIDER NETWORK – ACCESSIBILITY

Nothing in the Agreement shall restrict Pharmacy from informing, nor penalize Pharmacy for informing, a Member of any differential between the negotiated price of, or Cost Share for, the Covered Drug to the Member and a lower price the Member would pay for the Covered Drug if the Member obtained the drug without using an health insurance coverage.

PHARMACY COMMUNICATION

All participating Pharmacies within the EnvisionRx Network shall have a standard format method for receiving communications for continuing participation requirements, notifications of Network activities, and/or federal and state mandates. Email is the preferred method for Pharmacy communications by EnvisionRx. Pharmacies will be notified of any communications via email, fax, or standard mail (USPS).

QUALITY ASSURANCE

Your Pharmacy agrees to use commercially reasonable efforts to promptly respond to, resolve, and remedy any problems that may arise and to cooperate with Network in investigating and resolving any complaints from Members. Your Pharmacy agrees to use best efforts to immediately respond to, resolve, and remedy all Member clinical grievances presented by the Network within five (5) business days and to restore goodwill to Members to Network's and Plan Sponsors' or Program Sponsors' satisfaction. Your Pharmacy will exercise professional judgment in the provision of Covered Drugs to Members, and will council Members on their drug therapy as may be indicated. In addition, your Pharmacy will refrain from making disparaging comments to Members about Network, Plan Sponsors or Program Sponsors. Your Pharmacy will educate its pharmacists and other employees who have contact with the Members on this topic.

NETWORK PHARMACY COMPLAINT PROCESS

Complaints about Pharmacy services and/or disparaging comments received for any participating Pharmacy contracted within EnvisionRx Network(s) are handled by the EnvisionRx Provider Relations Department. Provider Relations will collaborate, as needed, with other departments within EnvisionRx to resolve the issue(s) as quickly as possible. As per the Participating Provider Agreement, a Pharmacy is prohibited from making disparaging comments related to EnvisionRx and/or its Affiliates or Plan Sponsors to any Member.

COMPLIANCE WITH LAWS

The Pharmacy must comply with applicable laws, regulations and guidelines in performing the Pharmacy services, including but not limited to: the Anti-Kickback Statute, the False Claims Act, and HIPAA.

INVESTIGATIONS AND DISCIPLINARY ACTIONS

The Pharmacy must immediately notify EnvisionRx if its license or permit is suspended or revoked; if any disciplinary action has been taken against the Pharmacy or the Pharmacy's personnel by any regulatory body or law enforcement; or there is a seizure by law enforcement of any Pharmacy property (e.g. prescription records, accounts, computers). The Pharmacy Help Desk is available 24 hours a day, 7 days a week, 365 days per year including holidays, at: 800-361-4542 (TTY Users may call 711).

CHANGE OF INFORMATION

Unless otherwise specified, the Pharmacy must notify EnvisionRx in writing within thirty (30) days of any changes in documentation or other information provided to EnvisionRx in connection with enrolling as a participating Pharmacy.

For changes of ownership, the Pharmacy must notify EnvisionRx in writing no later than fourteen (14) business days of the change. Upon a change of ownership, the Pharmacy will be required to complete the EnvisionRx re-credentialing application.

EXCLUDED PARTIES

The Pharmacy is required to check the HHS OIG List of Excluded Individuals and Entities (LEIE), and the System for Award Management (SAM) Excluded Parties Lists System prior to the hiring (and monthly thereafter) of any new employee, temporary employee, volunteer, consultant, governing body Member, or subcontractor, to ensure that it does not employ or contract with a person or entity who is excluded from participating in any federal or federally funded health care program. If any person or entity employed by or under contract with the Pharmacy is found on the OIG LEIE,SAM or any Medicaid exclusion lists, the Pharmacy must immediately notify the Network and refund the Network any reimbursements made to the Pharmacy for any Claims submitted to Network by the excluded person or entity within ten (10) business days.

FRAUD, WASTE AND ABUSE TRAINING

CMS requires all participating Pharmacies to conduct both General Compliance and Fraud, Waste and Abuse training for their personnel (employees and contracted staff and vendors) who are engaged in the delivery of Medicare services. This training must be provided within ninety (90) days of contracting with EnvisionRx and annually thereafter. The Pharmacy must be able to demonstrate that its employees have satisfied these training requirements and must retain proof of such training for ten (10) years. Examples of proof of training may include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training. Upon reasonable request by EnvisionRx, your Pharmacy must be willing to offer written attestation to its compliance of this section.

SUSPENSIONS AND TERMINATIONS

EnvisionRx will monitor and suspend a Pharmacy from participation in its Network if the Pharmacy has been identified or under review for engaging in any behavior or practice that:

1. Poses a significant risk to the health, welfare, or safety of any Member; or
2. Promotes or commits fraud, waste, or abuse; or
3. Commits an act, omission or material breach that is contrary to the criteria set forth in the PPA and the Provider Portal.

In addition, EnvisionRx reserves the right to immediately suspend a Pharmacy upon becoming aware that the Pharmacy has been investigated, within the past five (5) years, or is currently under investigation by a federal or state governmental agency or regulatory body.

The following practices may constitute a breach of the PPA and may result in claims chargeback, suspension and termination from the Network, or other rights and remedies that may be available to EnvisionRx under the Agreement, or at law, or equity:

- Sharing ownership, partial ownership, officers, affiliates, principals or other relationships with pharmacies previously suspended or terminated from network;
- Shipping medications or supplies to members without their consent or initiation
- Shipping to states where pharmacy is not licensed
- Obtaining prescriptions through the use of telemarketing companies or services

- Submitting a large number of test claims
- Promoting drugs to patients, direct or indirectly, without prior relationship to patient
- Not collecting copayments (cost share) at time of service
- Utilizing secondary payer coupons or copayment cards that are not recognized or sponsored by pharmaceutical manufacturers, or offered through a recognized or verifiable patient assistance program operated by an independent charity in compliance with the OIG 2014 special Advisory Bulletin
- Using pharmaceutical manufacturer copayment cards or coupons for Part D or other federally-funded health program covered medications
- Not cooperating or providing access to books, records or facility during onsite audit
- Lack of pharmacist presence during an onsite audit
- Adjudicating components of a compound drug as separate ingredients, single-NDC claims
- Adjudicating claims for compound drugs in which the ingredients are not supported by a medically acceptable indication through the same administration route for the condition being treated
- Adjudicating claims for compound drugs in which the same or similar formulation is present on the market
- Finding inventory shortages upon invoice reconciliation when comparing pharmacy drug utilization and purchase invoice records
- Insufficient records of inventory transfer(s) from/to commonly owned pharmacy location
- Insufficient records of inventory transfer(s) from/to another pharmacy (ex. sale, merger, etc.)
- Omitting information or providing inaccurate data on the credentialing or recredentialing application
- Failure to respond to recredentialing request or audit
- Failing to complete and attest to the annual Medicare Part D FWA Training and general Compliance Trainings
- Refusing to service a member because of the reimbursement rate

If a Pharmacy is being investigated for any reason, EnvisionRx reserves the right to suspend the Pharmacy, until the investigation is complete. Once the investigation is completed, the Pharmacy will either be reinstated or terminated from participating in the Network. Unless otherwise specified by law, any Claims processed by the Pharmacy that are determined as invalid or ineligible Claims, if applicable, the entire Claim cost can be recouped by the Network, including any dispensing fee(s).

EnvisionRx may temporarily withhold payment or cancel checks, in whole or in part, and/or prevent claims adjudication during the suspension period.

EnvisionRx's remedies under this section include termination of the Pharmacy from the Network. These termination rights are in addition to any and all other rights and remedies that may be available to EnvisionRx under the Agreement, or at law, or equity.

Pharmacy may submit an appeal of the suspension or termination to EnvisionRx by writing to the address provided in the Agreement notice within fourteen (14) days of receipt of such notice. The written appeal submitted by the Pharmacy must include supporting documents in order to be considered for reinstatement into the Network.

PROCESSING A CLAIM

BIN NUMBER AND PCN INFORMATION

Current BIN and PCN numbers can be located on the EnvisionRx website at: https://www.envisionrx.com/PrescribersAndProviders/Pharmacies#ProcessingInformation. PCN numbers must be entered with all capital letters. Please see the Medicare Part D section for more information regarding Part D BIN requirements.

ELECTRONIC CLAIMS TRANSMISSIONS REQUIREMENT

Pharmacy shall, within three (3) days of compounding or dispensing a Covered Drug to a Member, submit online to Network via Network's System, a Claim for payment in NCPDP format. Pharmacy shall bill Network using the 11 digit National Drug Code (NDC) number for the drug dispensed. Pharmacy must submit as part of the pricing information submitted for each prescription, its Usual and Customary Price (U&C) and submitted ingredient cost. Network shall not be liable for any transmission charges for Claims data.

Along with such Claim, Pharmacy shall submit to Network or its designated processor the following information: (i) the Member's name; (ii) identification number; (iii) group number (for Member under a group plan contract); (iv) service date; (v) Pharmacy NCPDP or NPI number with service provider qualifier; (vi) prescription number; (vii) NDC number; (viii) quantity dispensed; (ix) prescribed days' supply; (x) prescribing practitioner's DEA or NPI number and prescribing provider qualifier; (xi) Average Wholesale Price (AWP), Wholesale Acquisition Cost (WAC), or such other pricing methodology as has been adopted by the industry; (xii) dispensing fee as described in the Plan Sheets attached to the Agreement; and (xiii) copayments, deductibles or coinsurance collected from Member.

Pharmacy acknowledges and agrees the prescribing practitioner's NPI must be submitted for all Medicare Claims.

EnvisionRx requires all participating Pharmacy providers to be Health Insurance Portability and Accountability Act (HIPAA) compliant with all electronic Claim transactions utilizing the NCPDP version D.0 Telecommunication Standard format.

EnvisionRx recognizes "Dispense As Written" (DAW) Codes 0, 1, 2, 3, 4, 5, 7, and 9 only. The DAW field drives reimbursement of the prescription and the Member copayment. This field must be populated correctly; the DAW data entered by the Pharmacy may be subject to retrospective review. For formulary mandated drugs, DAW code 9 must be submitted.

1. *ONLINE SYSTEM DOWN-TIME TRANSMISSION PROCEDURES*

   In the event a party's Claims adjudication System (as referenced in the PPA as the Network and/or Pharmacy "System") is unavailable, your Pharmacy should attempt to resubmit the Claim not later than 30 days of the date the prescription was filled. "System" means the real-time on-line electronic Claims System used by the parties to access and relay information including, amounts collectible from Beneficiaries, amounts payable under this Agreement, and certain operational policies and procedures as established by PBM.

2. *CLAIMS REVERSALS AND CLAIM ADJUSTMENTS*

   If your Pharmacy needs to resubmit a Claim previously processed through the System, the original Claim must first be reversed prior to the Claim resubmission. Reversals must be made within 60 days from the date your Pharmacy ran the Claim through the System. Once a reversal is submitted and accepted, an adjusted Claim may be transmitted. For prescriptions billed to EnvisionRx that are not picked up by the Member,

EnvisionRx requires Pharmacies to reverse the Claim via the System within 14 days from the date the prescription was filled. EnvisionRx reserves the right to audit for prescriptions that were not picked up by the Member to ensure appropriate Claim reversals. Your Pharmacy may need to contact your online Systems software vendor for information about how to submit a Claim reversal.

If your Pharmacy was unable to reverse Claims over 60 days from the date of service via the System, you should contact the Pharmacy Help Desk at 800-361-4542 (TTY Users may call 711).

ACCURATE CLAIM SUBMISSION AND PRESCRIPTION RECORD

1. Submission of Accurate Claims
    a. Claims in which the accurate days' supply is modified in order to obtain a paid Claim are considered recoverable, depending on plan benefit limitations.

    b. Claims should be billed with quantity and days' supply consistently matching the directions for use and within plan benefit limitations. If the directions for use are not specific, such as "use as directed" or "apply to affected area", clarification must be obtained from prescriber and documented accordingly on the prescription hard copy or the pharmacy's electronic record system.

    c. Ensure the max daily dose (MDD) is present on use as directed (UAD) and sliding scale instructed prescriptions to avoid discrepancies and chargebacks.

    d. Smaller package size should be billed if it meets the prescriber directions and remains within the maximum days' supply limitation set up by the plan.

    e. Splitting prescription (lowering prescribed quantity) to bypass adjudication messages indicating requirement for prior authorizations or outreach to the Pharmacy Help Desk is not allowed, and will be subject to audit chargebacks.

    f. The NDC number of the dispensed drug, matching the package size, must be billed to accurately reflect the dispensed product. Billing of similar NDC is not allowed and will be subjected to audit chargebacks, according to audit findings. Wholesaler invoices and other drug related records should outline NDCs and drug names to be considered valid.

    g. The dispensing pharmacy NPI number must be used for claims submission, unless otherwise authorized in writing by EnvisionRx. Utilizing another pharmacy NPI number for submission of claims is subject to audit review and chargebacks.

    h. Claims adjudicated with incorrect prescriber NPI or identifiers, or incorrect origin codes, will be subject to adjustment or reversal if the adjustment results in claim rejection.

    i. A pre-printed substitution drug is not valid without a new prescription or a properly documented verbal authorization from prescriber.

2. Standards for Ophthalmic and Otic Drops: Unless indicated otherwise by manufacturer:

a. Solutions - 20 drops/mL
b. Suspensions - 15 drops/mL

3. Topical Products, Drops, Inhalers: When calculable directions are not specified, the smallest commercially available package size should be dispensed. If a larger amount is required, the frequency and surface area (for topical products) or maximum daily dose documentation is required on the prescription at the time of dispensing.

4. Return to Stock: Billed Claims must be reversed after fourteen (14) days if prescription is not picked up or received by the patient. Receipt of medications post fourteen (14) days of billing is subject to audit chargebacks.

5. Override and DUR Codes: All NCPDP override DUR coding should accurately reflect the reason for DUR override. If the Pharmacy utilizes an override code in order to obtain a paid Claim (i.e. 1B for "clarified with prescriber") the interaction must be documented on the prescription or in the Pharmacy System with traceable time stamps. Lack of supporting documentation is subject to audit chargebacks. Dispensing pharmacists should review DUR codes based on their clinical judgement, expertise and using applicable direction from governing organizations (e.g. Centers for Medicare and Medicaid Services). A Therapeutic Duplication (TD) message or edit requires a review of the patient's utilization history within the previous 30 days, as it indicates an attempt to fill a medication within the same drug class. There may be claims from other pharmacies. In these circumstances it is expected that the pharmacy seek clarification about therapy from either the member or the prescriber. If a clarification effort is made then the pharmacist should document information obtained from clarification and utilized to make a clinical decision. The pharmacist may override the rejection, if any, by using applicable Reason, Professional and Result codes.

6. Telephoned Prescriptions: Called-in prescriptions or verbal authorizations/ clarifications added to any prescription must be documented with date and name of caller. Missing information is subject to audit chargebacks.

7. Signature Log Requirement: Electronic or Manual Signature should be recorded at time of pick-up or delivery by the member or designated member representative. The record should include the date of pick-up or delivery and prescription number. For deliveries, the date delivered cannot be pre-printed by the pharmacy.

8. Prescriptions Delivered by common carrier (Mail, FedEx, UPS etc.): For delivery logs, a tracking number alone is not considered a valid proof of Member receipt. The tracking number must be accompanied by Member signature or tracking detail from carrier showing medication was delivered.

    a. Auto-ship requirements: A pharmacy that is mailing prescription drugs must obtain the member's (or member's authorized representative) authorization prior to the delivery of medication. This requirement applies to both new prescriptions and refills. Such confirmation is unnecessary when the beneficiary personally initiates the refill or new prescription request (for example, by mailing prescription to the pharmacy). The pharmacy is required to keep documentation related to authorization for delivery on file for audit purposes.

9. Long Term Care Pharmacy Considerations:
    a. Orders must indicate the time frame for which they are valid. Original orders without indication of number of refills are invalid if billed outside of the time frame indicated on the prescription.

b. Facility nursing staff call in notes, refill stickers or electronic refill requests are only valid to show intent to refill and not considered to be a valid order.

c. Prescription delivery should not take place before the date of service billed and no later than the following day

d. Additional documentation might be required from the Pharmacy depending on the circumstance, such as medication administration records (MARs).

e. MARs are not considered valid proof of delivery, but may be requested from time to time to assure patient utilization of medication.

10. Compound Prescriptions

COMPOUND PRESCRIPTION DEFINITION

"Compound Prescription" means a prescription for medication which would require the dispensing pharmacist to produce an extemporaneously produced mixture containing at least one Covered Drug that is a Federal Legend drug, the end product of which is not available in an equivalent commercial form. A prescription will not be considered a Compound Prescription if the medication is reconstituted or if the only ingredient added to the prescription medication is water, alcohol or a sodium chloride solution. Compound Prescription means any Claim in which a Compound Drug is adjudicated.

COMPOUND PRESCRIPTION CLAIM SUBMISSION

Compound Prescription Claims should be submitted by entering compounding indicator "2" and listing all the NDC's ingredients in the compound, the quantity used for each NDC and the submitted ingredient cost for each NDC. Your Pharmacy will be reimbursed for Compound Prescriptions based on covered ingredients. Your Pharmacy will not be reimbursed for the non-covered ingredients (e.g. water, alcohol, or sodium chloride solution). Your Pharmacy will be reimbursed the lesser of the Pharmacy's U&C or ingredient cost plus a dispensing fee, minus the Member Cost Share (copayment, coinsurance or deductible). Ingredient cost is based on Medi-Span's Average Wholesale Prices (AWPs) as reflected in the System at the time the prescription was filled, minus the discount reflected in the PPA and/or Plan Sheets.

1. Compound logs must be in accordance to Chapter 795 of the United States Pharmacopeia (USP 795) for non-sterile products and Chapter 797 (USP 797) of the United States Pharmacopeia for sterile products as well as applicable state law or regulation. When sending documentation include the master formula. The billing log or detail will not be considered in lieu of compound log.

2. The amount billed for each component must correspond to the amount dispensed to the patient/ amount used on the compound. Quantities billed in excess to make up to the entire package size are considered excessive and will be subject to chargeback.

3. The NDC numbers billed must correspond to the NDC numbers dispensed. If Pharmacy bills for an NDC that was not used on the actual compound, this is subject to chargeback.

4. Manipulation of rejected Claims in order to obtain paid Claims by excluding covered NDCs from Claim submission, misrepresenting U & C and others are not acceptable practices and will result in audit recoveries. Pharmacy must not modify the quantity or chemical entity of each individual

component in order to obtain Claim reimbursement. Pharmacy should not manipulate the compound indicator or pricing to bypass utilization management edits (i.e. Max Dollar or Max Quantity). Such findings are subject to audit chargeback and other corrective actions.

5. EnvisionRx does not permit substitution for compounds without a new prescription or a properly documented verbal authorization from prescriber. EnvisionRx does not consider compounded medication as a generic drug for the purposes of any applicable state generic substitution law or regulation.

6. If requested by EnvisionRx, pharmacy must provide clinical evidence for utilization of each chemical entity within the compound with literature on file supporting the therapeutic value. The chemical entities submitted in the compound drug claim fields should be used for a medically accepted indication to treat a covered condition, illness and injury, applicable to the compound route of administration.

7. Compound products should be billed and dispensed as a final compounded product. Therefore, billing each ingredient as single source drug for a drug meant to be used as a compounded drug constitutes inappropriate billing and is subject to chargebacks.

8. Compound products should be billed and dispensed based on an individualized prescription and treatment plan for identified Members. Pharmacies may not produce, distribute, or accept pre-printed or pre-populated prescriptions for compound products.

REIMBURSEMENT AND COST SHARE

For each Covered Drug dispensed at a Pharmacy location, Network will pay Pharmacy the lesser of the negotiated rate plus dispensing fee as set forth below or U&C.

EnvisionRx will deduct the Member Cost Share (copayments, coinsurances, and deductibles) from your Pharmacy's reimbursement. Your Pharmacy must collect the full amount of the Member's Cost Share as determined by the EnvisionRx Network System.at point-of-sale. Copayments, coinsurances or deductibles are not eligible to be discounted or excused/waived at any time by your Pharmacy. And you may not collect copayments, coinsurances and deductibles that exceed your Pharmacy's U&C. Payments received from programs other than verifiable charitable foundations or manufacturer sponsored or recognized program are considered discounted/ waived which is prohibited.

ALL LINES OF BUSINESS

INITIATED PRESCRIPTIONS

Pharmacy shall not deliver Covered Drugs to a Member without the Member's consent prior to each delivery. Additionally, Pharmacy agrees that it will not bill for reimbursement for Member's Covered Drug prescriptions until and unless the Member has received such prescriptions.

IDENTIFICATION CARDS

All information to process a Claim is included on the Member ID Card. The Pharmacy is required to process the Claim using the Member information unless the Member expressly requests that a Claim not be submitted to the insurer.

Please note: the Member ID is normally a unique number that may contain alpha characters. EnvisionRx also utilizes a relationship designation which may or may not be printed on the card.

The card normally contains the following information when issued by EnvisionRx:

1. The Member's name on the card with a Member ID consisting of up to 15 characters which may be alpha numeric but will not contain Member's Social Security Number.
2. The family Member card will either list the Member's full name with no dependents or the Member's last name with dependents. The relationship code for the dependents may or may not be listed on the card. The Member cardholder will have 01 as the person code and spouses will have 02 and other dependents may be listed by first name on the card and use the person codes 03, 04 etc., respectively.
3. On the back of the card, there is a toll-free number which clearly identifies how to reach our Pharmacy Help Desk. The Pharmacy Help Desk is staffed 24 hours a day and 7 days a week, 365 days a year – including holidays.

Be certain to verify the ID number on the Member's EnvisionRx prescription card before transmitting a Claim in order to avoid a rejection, subsequent adjustment, or the processing of the Claim improperly under another Member's eligibility.

In order to process a Pharmacy Claim, the entire Member number including the two digit person code must be submitted for each Claim. After processing the Claim, the Member must pay the co-payment or coinsurance for any drug covered under the Member's Pharmacy prescription plan.

EDITS

FRAUD WASTE AND ABUSE EDITS

EnvisionRx clients may choose to apply edits for Fraud, Waste and Abuse purposes. These edits typically fall under 2 categories:

1. Max Quantity Limits – maximum quantity of medication that can be dispensed over a specific period of time at the applicable copayment, coinsurance, or deductible.
2. Max Dollar Limits – maximum amount of money that an insurance company (or self-insured company) will pay for Claims within a specific time period.

Both of these edits are designed to confirm that the Pharmacy is dispensing the appropriate dose/quantity based on the prescriber's directions. Below are some examples of reject messaging that you will receive at the Pharmacy:

Reject 76: Plan limitations exceeded – MH

Reject 76: Potential FWA please call 1-866-417-3069

If you receive messages related to max quantity or max dollar on a rejected Claim, you must contact the Pharmacy Help Desk at 800-361-4542 or the number listed on the rejected Claim messaging (TTY Users may call 711). You will be asked to confirm the drug name, dosage form, strength and directions from the prescriber and then an override may be placed in the System for the Claim to be resubmitted.

DRUG UTILIZATION REVIEW (DUR) EDITS

Claims can be rejected based on Medi-Span DUR edits in the following categories: Therapeutic Duplication, Drug-Drug Interaction, Ingredient Duplication, Drug Age Precaution, and High Dose. The plan sponsor may select soft or hard rejections to be applied to these DUR edits.

When a hard rejection occurs, the only way to override the Claim is to contact the Pharmacy Help Desk at 800-361-4542 or the number listed on the rejected Claim messaging (TTY Users may call 711).

When a plan sponsor selects a soft rejection, the rejection may be overridden by following the below instructions:

The Pharmacy populates the following fields with NCPDP standard service codes to override the DUR reject:

1. Professional Service Code NCPDP field = 44Ø-E5.
2. Reason for Service Code NCPDP field = 439-E4.
3. Result of Service Code NCPDP field = 441-E6.

The DUR conflict code should be the deciding factor on which combination of service codes are submitted to override the rejection.

DUR Conflict Code	Description	Prof Service Code	Reason for Service Code	Result of Service Code
TD	Therapeutic Duplication	MR	TD	1B
DD	Drug-Drug Interaction	MR	DD	1B
ID	Ingredient Duplication	MR	ID	1B
PA	Drug Age Precaution	MR	PA	1B
HD	High Dose	MR	HD	1B

Drug-Drug Interaction: *Reject 88:*

- *Use DD, MO/MR, 1B/1G. For >1 alert use 00000000003*

Dose Check-High Dose Interaction: *Reject 88:*

- *Use HD, DE/MO/MR, 1B/1G. For >1 alert use 00000000003*

Drug-Age Interaction: *Reject 88:*

- *Use PA, MO/MR, 1B/1G. For >1 alert use 00000000003*

Drug-Sex Interaction: *Reject 88:*

- *Use SX, MO/MR, 1B/1G. For >1 alert use 00000000003*

Duplicate Drug: *Reject 88:*

- *Use ID, MO/MR, 1B/1G. For >1 alert use 00000000003*

Duplicate Therapy: *Reject 88:*

- *Use TD, MO/MR, 1B/1G. For >1 alert use 00000000003*

Please note that all NCPDP override DUR coding should accurately reflect the reason for DUR override. If the Pharmacy utilizes an override code in order to obtain a paid Claim the interaction (or rationale) for approval must be documented on the prescription or in the Pharmacy System with traceable time stamps. For example, for override code 1B ("clarified with prescriber") a record should be made to support clarification and interaction. Lack of supporting documentation is subject to audit chargebacks. Please refer to section on ACCURATE CLAIM SUBMISSION AND PRESCRIPTION RECORD/ Override and DUR codes.

Point of Sale (POS) Opioid Patient Safety Edits

Point-of-sale (POS) opioid patient safety edits will be enforced for Medicare Part D claims processed by EnvisionRx, effective January 1, 2019. Guidance for managing and resolving each type of opioid safety rejection follows. The following edits have been established for high opioid doses or opioid combinations that may increase risk of adverse events. Documentation is needed to support use and EnvisionRx encourages Pharmacies to verify coordination of care when more than one prescriber is involved. EnvisionRx further encourage the downward titration of opioids and efforts to lessen member dependence on opioids whenever possible.

Seven Day Supply Limit for Initial Opioid Fills (Opioid Naïve). Point-of-sale (POS) edit limiting opioid analgesic prescriptions to a seven day supply for members considered to be opioid naïve.

Reject Code	925
Reject Message	MEMBER IS OPIOID NAÏVE: SEVEN DAY SUPPLY ALLOWED; CALL FOR OVERRIDE ASSISTANCE OR PA REQUEST.
Resolution	Decrease prescription quantity and day supply to seven days or less and resubmit the claim.
Resolution Alternatives	Service codes may only be used when the following apply: Member is being actively managed by hospice Member's opioid is for 'Active' cancer pain Member has an opioid claim within the last 120 days
Reason for Service Code	MX: Excessive duration
Professional Service Code	MØ: Prescriber consulted MR: Medication review
Result of Service Code	4C: Dispensed, hospice 4D: Dispensed, cancer treatment 4J: Dispensed, patient is not opioid naïve

Cumulative Daily 200 Morphine Milligram Equivalence (MME). POS edits requiring prescriber attestation to ensure member safety when the cumulative daily MME reaches 200 mg or greater.

Reject Code	88
Reject Message	200 MILLIGRAM MORPHINE EQUIVALENCE LIMIT: PRIOR AUTHORIZATION REQUIRED.
Resolution	Member or member's representative must submit a coverage determination request to EnvisionRx for review.

Care Coordination Edit (90 MME). POS edit requiring prescriber attestation to ensure member safety when the cumulative daily MME reaches 90 mg or greater.

Reject Code	88
Reject Message	90 MG MORPHINE EQUIVALENCE LIMIT: CONSULT PRESCRIBER AND ENTER DUR CODES IF APPROPRIATE;OR PA REQUIRED
Resolution	Service codes may be entered after the dispensing pharmacy verifies through prescriber consultation that meeting or exceeding 90 MME for the given member is intended and safe.
Resolution Alternatives	If the dispensing pharmacy is unable to verify opioid safety with the prescriber or deems the situation clinically inappropriate, the member or member's representative may submit a coverage determination request to EnvisionRx for review.
Reason For Service Code	DR: Dose range conflict
Professional Service Code	MØ: Prescriber consulted
Result of Service Code	1G: Filled with prescriber approval 4C: Dispensed, hospice 4D: Dispensed, cancer treatment

Duplicate Extended-Release/Long-Acting (ER/LA) Opioid Therapy. POS edit requiring a safety review by the dispensing pharmacy when a member is concurrently utilizing more than one extended release/long-acting (ER/LA) opioid analgesic.

Reject Code	88
Reject Message	MULTIPLE ER/LA OPIOID USE: REVIEW OPIOID HISTORY AND ENTER DUR CODES IF SAFE TO USE >1 ER/LA OPIOID
Resolution	Dispensing pharmacy should enter applicable service codes after verifying it is safe and appropriate to utilize more than one extended release opioid analgesic.
Reason For Service Code	SD: Suboptimal drug/indication
Professional Service Code	MØ: Prescriber consulted MR: Medication review
Result of Service Code	1B: Filled prescription as-is 1G: Filled with prescriber approval 4C: Dispensed, hospice 4D: Dispensed, cancer treatment

Concurrent Opioid and Benzodiazepine Use. POS edit requiring a safety review by the dispensing pharmacy when a member is utilizing an opioid analgesic in combination with a benzodiazepine.

Reject Code	88
Reject Message	ADDITIVE TOXICITY ALERT: *REVIEW HISTORY OF BENZODIAZEPINE USE;* ENTER DUR CODES IF SAFE & APPROPRIATE
Reject Message	ADDITIVE TOXICITY ALERT: *REVIEW HISTORY OF OPIOID USE;* ENTER DUR CODES IF SAFE & APPROPRIATE
Resolution	Service codes may be entered only after verifying that it is safe and appropriate for the member to use opioid analgesics along with benzodiazepines.
Reason For Service Code	AT: Additive toxicity
Professional Service Code	MØ: Prescriber consulted MR: Medication review
Result of Service Code	1B: Filled prescription as-is 1G: Filled with prescriber approval 4C: Dispensed, hospice 4D: Dispensed, cancer treatment

Concurrent Opioid and Buprenorphine Use. POS edit requiring a safety review by the dispensing pharmacy when a member is utilizing an opioid analgesic in combination with a buprenorphine product indicated only for the treatment of opioid dependence.

Reject Code	88
Reject Message	OPIOID DEPENDENCE TREATMENT ALERT: ENTER DUR CODES IF APPROPRIATE TO USE OPIOIDS WITH BUPRENORPHINE.
Resolution	Service codes may be entered only after verifying it is appropriate for the member to utilize an opioid analgesic in the presence of opioid dependence treatment with buprenorphine.
Reason For Service Code	DC: Drug-disease (inferred)
Professional Service Code	MØ: Prescriber consulted MR: Medication review
Result of Service Code	1B: Filled prescription as-is 1G: Filled with prescriber approval 4C: Dispensed, hospice 4D: Dispensed, cancer treatment

COORDINATION OF BENEFITS (COB)

Coordination of Benefits is a provision used to establish the order which health insurance plans pay Claims when more than one plan exists. In cases where there is other coverage involved, the following will apply to the Claim submission:

1. Accepted Values:
    - 00 – Not specified
    - 01 – No other coverage identified
    - 02 – Other coverage exists, payment collected
    - 03 – Other coverage exists, this Claim not covered
    - 04 – Other coverage exists, payment not collected
    - 08 – Claim is billing for copay

2. When the COB field (308-C8) is populated, the Pharmacy must submit the appropriate values in:
    - 431-DV: OPA*required for Government COB Processing only
    - 430-DU: Gross Amount Due (OPPRA)
    - 352-NQ: PRA (OPPRA)

AUDIT GUIDELINES

INTRODUCTION

In accordance with the Participating Provider Agreement, EnvisionRx has the right to audit Pharmacies in the EnvisionRx Pharmacy Network ("Pharmacies"). These guidelines will provide Pharmacies with an overview of Network compliance and Pharmacy audit procedures.

Audit results are regularly reviewed by EnvisionRx's Benefit Integrity and Credentialing Departments, and any discrepancies found may result in payment chargebacks or referrals to state/federal investigative agencies, may impact Pharmacy participation in the EnvisionRx Pharmacy Network, or other corrective action.
The information provided within these guidelines may not be specific to your Pharmacy. Please refer to your Participating Provider Agreement or PSAO/Chain Network Agreement for specific information related to your Pharmacy. Federal, state, or local law, regulation or guidance varies and may supersede these audit guidelines. If there is a conflict between an applicable law, regulation or guidance, to the extent permissible, the audit will follow the stricter provision.

TYPES OF AUDITS

EnvisionRx may conduct a desk audit, on-site audit, or investigational audit of a Pharmacy. Nothing prohibits EnvisionRx from conducting an audit that does not follow these audit guidelines as long as such audit is in compliance with applicable federal, state, or local law, regulation or guidance.

1. Desk Audits: Desk audits are generated according to proprietary algorithms that flag Pharmacy data, and performed on a random basis for verification of Pharmacy compliance. Audits are conducted in writing via email or fax communication. Documentation is requested to confirm billing practice and Member receipt. Many Medicare and/or Medicaid Plan Sponsor-requested desk audits follow stricter timeframes and as a result have short turnaround times.

2. Onsite Audits: Onsite audits are audits that are conducted at the Pharmacy's physical location. As a routine practice, advanced notification of audit will be sent via mail to schedule the onsite audit. Written notification is not mandatory for an onsite audit to occur. During the onsite audit, prescription hard copies and signature logs should be made readily available for the auditor. Prior to the onsite visit, a parameter of fill dates and prescription numbers are provided. Unprofessional or unsafe Pharmacy practices observed during an onsite audit may result in actions taken against the Pharmacy up to and including termination of the Pharmacy contract, issuance of corrective actions and/or be reported to applicable regulatory agencies.

3. Investigational Audits: Investigational audits are desk audits that are more extensive and detailed in scope compared to desk or onsite audits. Depending on the issue(s) being investigated, additional documentation may be requested from the Pharmacy that goes beyond the typical request for copies of prescriptions and delivery logs. The time frames for documentation review might be extended depending on the nature of the investigation.

REQUESTED DOCUMENTATION AND RECORDS

The Pharmacy must provide EnvisionRx, Plan Sponsors, and governmental agencies, and their authorized agents and representatives with a copy of any and all records necessary to determine compliance with applicable law, regulation or guidance and the Participating Provider Agreement. Records subject to audit include, but are not limited to, the following:

1. Prescription hard copy (front and back)
    a. LTC: Physician's order sheet for date of service
    b. If the requested copy is a vaccine prescription and the vaccine was both dispensed and administered at your location, please include the Vaccination Administration Record (VAR)
2. Prescription label
3. Signature log (or valid proof of delivery)
4. Compound log
    a. If compounded medication and/or if compounded in bulk [i.e. for multiple patients from same formula] include the record for master preparation
5. Manufacturer, wholesaler, and distributor invoices and pedigrees
6. Any other documentation required by applicable federal, state or local law, regulation or guidance.

See additional information in section labeled ACCURATE CLAIM SUBMISSION AND PRESCRIPTION RECORD

TYPICAL AUDIT PROTOCOL AND APPEALS PROCESS

EnvisionRx provides the following claims audit protocol and appeals process:

- The Pharmacy is given thirty (30) calendar days to respond to the audit request.
- If any discrepancies are encountered, the initial findings will be sent to the Pharmacy.
- The discrepancy letter provides an explanation of the identified discrepancy and acceptable appeal documentation. Thirty (30) days are given to submit an appeal.
- Upon completion of the appeal review, a decision letter is sent to the Pharmacy with the final findings.

Time frame allowances described above will be shortened for investigative reviews, Plan Sponsor requests, CMS requests, or audits initiated as a result of member complaint.

EnvisionRx has the right to off-set for any amounts due where permissible by applicable law or regulation.

WHOLESALER, MANUFACTURER AND DISTRIBUTOR INVOICES: REQUIREMENTS AND AUDITS

Wholesaler, manufacturers and distributor invoices are subject to audit and must be provided to EnvisionRx when requested. It is the Pharmacy's responsibility to ensure that all wholesalers, manufacturers and distributors utilized to provide covered drugs to Members are lawfully licensed to do so. Covered drug products in this context include OTC items and supplies.

In order to source medication inventory from another licensed pharmacy, the following requisites must be met:

1. The supplying pharmacy must be licensed as a wholesaler unless otherwise specified in applicable law
2. The Pharmacy must maintain documentation about the sourced medication. This documentation must include, at minimum, the following items: medication name and strength; medication NDC; lot number; exact quantities purchased; date of purchase; proof of financial transactions between both pharmacies

In order to transfer medication inventory from another licensed pharmacy, the following requisites must be met:

1. The Pharmacy must maintain documentation about the medication transfer. This documentation must include, at minimum, the following items: medication name and strength; medication NDC; lot number; exact quantities purchased; date of purchase; proof of financial transactions between both pharmacies
2. Unless otherwise specified in the PPA or applicable law, if the transfer is related to the sale, merger or inventory consolidation, then the Pharmacy must conduct a full inventory while documenting the items listed above.

Important points to remember:

- Pharmacy must be able to provide, upon request, the pedigree information for dispensed drug products.
- All wholesaler/ distributor invoices or purchase summaries must be submitted directly from the wholesaler.
- Documentation received from the pharmacy will not be accepted for audit consideration.
- Pharmacy must provide comprehensive drug utilization report upon request; this report includes all payers for the NDCs requested (PHI should be redacted). A denial of this request constitutes a denial of access to records.

FREQUENTLY ASKED QUESTIONS

1. *What happens if a partial or illegible communication is received by the Pharmacy?*
    a. Send an email to PharmacyAudits@envisionrx.com or fax inquiry to 844-236-3021
    b. Include the Pharmacy's NABP or NPI and the Audit Ref# (if legible) in the subject line of e-mail or fax cover page
    c. Describe any decipherable information on the letter and the issue

2. *What type of documentation may be requested for a desk audit?*

a. Copy of the audit request letter with QR code (two-dimensional bar code)
b. Copy of the original prescription (front and back)
    i. LTC Pharmacy: Physician's order sheet for date of service or interim order. Medication Administration Records (MAR) are not acceptable proof of prescriber order
    ii. If prescription is for a vaccine, include the Vaccination Administration Record (VAR)
c. Rx label: copy of label placed on the dispensed medication for the requested date of service
d. Copy of the signature log sheet (pickup or delivery) for verification
e. Compound log (if compounded medication)
f. Manufacturer, wholesaler or distribution invoices

3. *How does the Pharmacy submit requested documentation?*
    a. Use the bar coded audit request letter or most recent letter as the cover page of audit response
    b. Submit requested documentation via fax to 844-236-3021 or secure email to PharmacyAudits@envisionrx.com
    c. If you don't have secure e-mail, you can send a request to us advising of such and we can setup a secure link for document submission

4. *How do I address questions regarding an audit, including audit status?*
    a. Submit all questions and/or concerns in writing via email to PharmacyAudits@envisionrx.com or via fax to 844-236-3021 using bar coded audit letter

5. *What happens if my initial audit response is not received?*
    a. Locate fax confirmation or email communication
    b. Resubmit initial audit response along with fax confirmation or e-mail communications related to previous submission
    c. Upon evaluation of documentation, audit will be placed back for initial review.

6. *How do I update the Pharmacy contact for audit communications?*
    a. Audit communications can be sent via email or fax. They can't be sent via multiple mechanisms. If utilizing e-mail, we can accommodate up to two email addresses.
    b. Send update requests to PharmacyAudits@envisionrx.com
    c. It is the Pharmacy's responsibility to advise the EnvisionRx Benefit Integrity and Network Credentialing Departments of any change to fax or e-mail address on file

7. *How do I appeal audit findings?*
    a. Each discrepancy and decision letter contains a discrepancy table
    b. The discrepancy table includes a description of the discrepancy noted and the acceptable documentation for appeal
    c. Once all required appeal documentation is gathered, submit once within the thirty (30) days' time frame given (might vary for investigational audits). Use the discrepancy letter as the cover page to properly route to the audit.
    d. All appeals must be sent via encrypted email to PharmacyAudits@envisionrx.com or via fax to 844-236-3021

8. *Can I request an extension to respond to the audit or to appeal the initial audit findings*?
    a. Audit extensions are considered on a case by case basis. All requests for audit extensions are handled in writing only via email or fax: PharmacyAudits@envisionrx.com or to 844-236-3021.

9. *Can I still appeal if the initial audit response was not submitted*?
    a. Yes, gather requested documentation and submit your appeal via email to PharmacyAudits@envisionrx.com or via fax to 844-236-3021
    b. Use the discrepancy letter with the QR code (two-dimensional bar code) as your cover page

10. *Can my Pharmacy obtain a list with the prescriptions that will be reviewed during the onsite audit*?
    a. No, EnvisionRx does not provide a list with the exact prescription numbers prior to the audit. This is part of the procedure to maintain the integrity of the onsite visit. However, a parameter of fill dates and prescription numbers are provided in advance.
    b. Pharmacy will have opportunity to provide additional documentation during the appeal phase

11. *What happens if the tracking number is too old to retrieve from the mail courier website?*
    a. Contact your account representative at the mail courier to provide date and time of successful delivery. Excel files with pertinent tracking information are acceptable if coming directly from the carrier account representative.
    b. Alternatively, a Member attestation acknowledging delivery is acceptable
    c. Please note: a tracking number alone does not confirm Member receipt

Acceptable Audit Appeals

All audit discrepancy and decision letters will provide the reason a Claim has failed audit. The following chart provides the audit discrepancy codes and descriptions, as well as acceptable or required documentation to appeal a Claim marked as discrepant on an audit:*

CODE	Description	Explanation	Required Documents for Appeals
CFX	Cut Fax Header	Fax header removed from Rx document that would authenticate the origin submitted on claim as "Fax".	Prescriber statement*
CIN	Clinically Inappropriate	Billed claim goes against current accepted medical literature; without documentation of prescriber interaction and authorization.	Pharmacy and/or prescriber must provide current clinical literature validating the use of this drug and/or dose as prescribed.
COM	Missing or Incomplete Compound Log	Compound log not submitted or missing required elements.	Date and time stamped compound log with all required elements according to USP 795.
CPD	Compound Incorrectly billed	A compounded prescription is billed incorrectly resulting in overpayment, or claim is billed with an NDC number that was not used in the actual compound.	Compound logs with new elements other than what was initially submitted must contain verifiable date and time stamp or other traceable information to be considered.
DAW	Incorrect DAW Code	DAW billed must be documented on the prescription hard copy.	Date and time stamped note in patient profile that documents patient's preference (electronically captured documentation) or medical record that supports prescriber's preference.
DEA	DEA Number Not Documented on Prescription	The hard copy prescription does not contain a DEA number (CII-CV drugs only).	No post audit documentation accepted. Federal regulations require the prescriber's DEA number as part of the prescription hard copy PRIOR to dispensing.
DPU	Delayed Pick-up from billed Date of Service	Prescriptions billed and not picked up or delivered within 14 days from date of service should be reversed. No post audit documentation accepted.	No post audit documentation accepted.
EXC	Excessive Quantity Billed/Overfilled	The quantity billed exceeds amount authorized by the prescriber or the quantity billed would last greater than the days' supply limit of the plan.	Prescriber statement* acceptable in cases of quantity billed that exceeds amount authorized by prescriber.

CODE	Description	Explanation	Required Documents for Appeals
EXP	Expired Prescription	Prescription is filled greater than timeframe allowed by state and/or federal regulation.	Copy of the state or federal regulation defining the valid length of time the prescription can be filled.
IDS	Incorrect Days' Supply	The days' supply billed is not consistent with the quantity and directions described by prescriber.	No post audit documentation accepted.
INV	Invalid Prescription	Prescription does not conform to all applicable regulatory requirements.	Prescriber statement*. No post audit documentation accepted for CII-CV.
IOC	Incorrect Origin Code	Origin code submitted differs from the hard copy prescription.	No post audit documentation accepted; informational citation.
IPO	Invalid Physician's Order	Physician's order is not valid for the billed date of service.	Copy of physician's order or interim order that authorized the date of service billed.
ISH	Drug Invoice Shortage	Pharmacy billed for a higher quantity of drugs compared to amount purchased.	Invoice data submitted by the wholesaler(s) reported on the signed 'Pharmacy Attestation of Wholesalers'.
ITX	Incomplete Transfer Information	Prescription does not have complete transfer information.	Prescriber statement*. No post audit documentation accepted for CII-CV.
LAB	Missing or Incomplete Rx label	Rx label not received or does not conform to regulatory requirements.	A computer generated label or sticker with all defined Rx elements for requested date of service.
MDP	Member Denies Prescription	Member denied receiving the prescription or knowing the pharmacy.	Member statement** and member's explanation to justify initial claim(s) denied.
MDR	Member Denies Ordering/Requesting Prescription Received	Member denied ordering or requesting prescription billed to member's benefit.	Member statement** with explanation of initial denial, AND, pharmacy's call log recordings, or printout from the pharmacy system with date and time stamp or other traceable information.
MLL	Mis-labeled	Label discrepancy in which Rx directions are not accurately described on Rx label provided to patient.	If therapeutic impact, include incident report that documented the error in a timely manner and proof that the prescriber and patient were notified.
MSL	Missing Signature Log or Delivery Manifest	Signature log or proof of receipt by member not received.	Member statement** or facility statement*** confirming medication was received, OR signature captured electronically.
MSP	Missing Prescription	Copy of prescription cannot be found in documentation submitted.	Prescriber statement* or original prescription hard copy (front and back). Telephoned or called in prescription hard copies are not accepted during the appeal phase.
N	No Standing Discrepancy	No discrepancies encountered.	Not applicable
NPD	Not Part D	Claim not covered under Medicare Part D.	Will be specified depending on error.
NRS	No Response to Audit Request	Pharmacy failed to respond to audit request.	Original prescription hard copy (front and back) or prescriber statement*, Rx label, signature log and compound log (if applicable).
OTH	Other	Will be described depending on the error.	Will be specified depending on the error.
OTH2	Other	Will be described depending on the error.	Will be specified depending on the error.
PDP	Prescriber Denies Prescription	Prescriber denied authorizing prescriptions billed under his/her name.	Prescriber statement* with explanation to justify initial prescription denial and medical record to support prescriber statement.
PUMP	Drug infused using implantable pump for Part D plan	Drugs infused using implantable pump should be billed to Part B.	Pharmacy may provide records showing type of insulin pump used by member.
RMA	Risk Management Authorization	No risk management authorization number recorded on prescription to authorize dispensing.	Original documentation or an archived profile note in the pharmacy system with time and date stamp that documents the date and RMA number.

CODE	Description	Explanation	Required Documents for Appeals
RTS	Refill Too Soon	Refill too soon based on submission of correct days' supply.	No post audit documentation accepted.
SPL	Split quantity	Quantity billed is less than prescribed, resulting in frequent fills and dispensing fees and/or circumventing plan limitations.	No post audit documentation accepted.
SUP	Supervising MD Missing	Supervising MD name not on prescription hard copy written by mid-level practitioner.	Prescriber statement* from supervising MD. No post audit documentation accepted for CII-CV.
UAD	"Use As directed"/ No Directions Documented	Prescription hard copy missing specific, calculable directions.	Prescriber statement* containing one of the following specified directions 1.) Surface area and frequency or 2.) Maximum daily dose.
URF	Unauthorized Refills Billed	Refills for adjudicated claim are not specified on the prescription hard copy.	Prescriber statement* that indicates refill was authorized PRIOR to dispensing date.
WDD	Wrong Drug Dispensed or Billed	Pharmacy billed a different medication than the one ordered by the prescriber, with no documentation on prescription hard copy or member profile.	Prescriber statement* to verify authorized change. Appeal documentation accepted for substitution due to therapeutic exchange only.
WMB	Wrong Member Billed	The member identified on the prescription hard copy is not the member identified on the paid claim.	No post audit documentation accepted.
WPS	Wrong Prescriber Submitted	Incorrect prescriber submitted for claim adjudication or inappropriate use of prescriber ID.	If the correct prescriber has been sanctioned or otherwise excluded by payor, claim will be reversed. No post audit documentation accepted.
WSL	Wrong Signature Log	Signature log copy submitted is for a different date of service or different medication.	Signature log/Electronically captured signature for requested Date of Service, Member statement** or facility statement*** confirming medication was received.
XDEA	XDEA Number Missing	No XDEA number on Suboxone or Subutex prescription hard copy that is required for opioid dependence treatment.	No post audit documentation accepted.

**Prescriber Statement must be legible, be written on the prescriber's letterhead or on a pre-printed prescription blank that shows a fax header from the prescriber's office or an office stamp. The statement MUST include the following: 1) prescriber's full address and telephone number, 2) patient's name and date of birth, 3) medication, 4) strength and dosage form, 5) directions for use, 6) quantity prescribed, 7) refills (if any), 8) written or authorized date, 9) DAW indicator and 10) prescriber's handwritten signature.*

***Member statement must be legible and include the following: 1) patient's full name and address, 2) telephone number or contact information, 3) prescription number(s), 4) medication(s) and strength(s), 5) date(s) of service and 6) patient's signature.*

****Facility statement must be legible and include the following: 1) patient's name, 2) date of service, 3) prescription number(s), 4) medication(s) and strength(s), 5) quantity of medication delivered, 6) date of delivery, and 7) signature of staff who accepted delivery.*

CONTACT

If you have any questions concerning an ongoing audit, or general questions concerning any pharmacy audit related issues, please contact the EnvisionRx Benefit Integrity Department at PharmacyAudits@envisionrx.com or via the fax number listed on your audit letter. Please include the Pharmacy name, NCPDP #, contact information and audit ID # (if applicable). If faxing, please use the bar coded audit letter as your cover page.

DEFINITIONS

Abuse – intentional over-utilization or improper use of a drug that can result in potential Member harm and unnecessary costs.

Appeal – opportunity to dispute findings of an audit.

Audit – process of reviewing billed Claims according to prescription records, inventory records and signature logs.

Claims adjudication – billing entered by the Pharmacy according to the several elements on a prescription and the drug dispensed.

Discrepancy – an identified inaccuracy in a billed Claim according to submitted documentation. May or may not have financial impact.

Fraud – intentional misrepresentation of a Claim or service billed but not rendered.

Informational Citation – an identified discrepancy that does not have financial impact.

PDE – prescription drug event submitted to CMS for Medicare Part D.

Waste – billing a quantity above the plan benefit structure allowance according to days' supply.

HOW TO REPORT SUSPECTED FRAUD

You may report suspected fraud and other compliance issues anonymously to the EnvisionRx Compliance Hotline.

Via phone: 1-866-417-3069

Online: myethicsline.envisionrx.com

MEDICARE PART D

The Medicare Part D program has some unique requirements. Below is a summary of each requirement.

MEDICARE COVERAGE GAP DISCOUNT PROGRAM

The Affordable Care Act includes provisions to close the Medicare Part D prescription drug coverage gap (also known as the "donut hole") to make prescription drugs more affordable for people with Medicare. The first step in closing the coverage gap was the mailing of the one-time $250 rebate check to most people who reached the coverage gap in 2010. The second step to closing the coverage gap began January 1, 2011.

Effective January 2011, people with Medicare who have Part D coverage, but do not receive extra help (the low-income subsidy), will receive a 50% discount under the Medicare Coverage Gap Discount Program on "applicable" drugs at the point of sale and a 7% increase in coverage for all other covered Part D drugs (e.g., generic drugs and supplies associated with the delivery of insulin) while they are in the coverage gap. Over the next 10 years, prescription drug coverage will continue to increase for all Covered Drugs in the coverage gap so the amount people pay during the gap will continue to decrease until it reaches 25% in 2020.

WHAT ARE "APPLICABLE" DRUGS?

Applicable drugs are Part D prescription drugs approved under new drug applications (NDAs) or licensed under biologics license applications (BLAs). These are generally covered brand-name Part D drugs including insulin and Part D vaccines. Applicable drugs also include Part D prescription drugs that are commonly considered generic drugs, but actually have been FDA approved under NDAs. These drugs must be covered by a signed discount agreement to be covered under Part D. Beginning in 2011, only those applicable drugs that are covered under a signed manufacturer discount agreement with the Centers for Medicare & Medicaid Services (CMS) will be covered under Part D.

All other covered Part D drugs (e.g. generic drugs approved under abbreviated new drug applications (ANDAs) and supplies associated with the delivery of insulin) may continue to be covered by Part D plans irrespective of a signed manufacturer agreement. In addition, to be considered an applicable drug, drugs approved under ANDAs, BLAs and NDAs must all be properly listed with the FDA to process under Medicare Part D guidelines.

HOW WILL THE MEDICARE COVERAGE GAP DISCOUNT PROGRAM WORK?

Drug manufacturers must sign agreements with CMS to participate in the Medicare Coverage Gap Discount Program. The agreement specifies that all of the manufacturers' applicable BLA and NDA drugs will automatically be discounted by 50% at the point of sale for non-LIS Member' coverage gap Claims starting on January 1, 2011. The discount does not include the cost of the dispensing fee. The full cost of the drug will count as out-of-pocket spending for the purposes of reaching catastrophic coverage.

Example: Mrs. Anderson reaches the coverage gap. She goes to her Pharmacy to fill a prescription for an applicable drug. The price for the drug is $60 and the dispensing fee is $2. Once the 50% discount is applied, the cost of the drug is $30. The $2 dispensing fee is added to the $30 discounted amount. Mrs. Anderson will pay $32 for the prescription, but the entire $62 (both what Mrs. Anderson and the manufacturer pay) will be counted as out-of-pocket spending and will help Mrs. Anderson reach the end of the coverage gap.

If a drug manufacturer doesn't sign a discount agreement with CMS, its applicable drugs won't be covered under Part D, and Part D sponsors won't be allowed to grant an exception or provide a transition fill for such drugs. People may still buy the drug at its full price, but the cost won't count towards the progression through the coverage gap. Medicare Part D plans will review coverage gap Claims to determine the person's eligibility and if the drugs are eligible for the discount.

HOW WILL MY PHARMACY KNOW WHICH MANUFACTURERS HAVE SIGNED A COVERAGE GAP DISCOUNT PROGRAM AGREEMENT WITH CMS?

CMS publishes a listing of companies that have signed an agreement along with the associated five-digit labeler codes on its Web site. The listing of labeler codes and manufacturers can be found at www.cms.gov/PrescriptionDrugCovGenIn. Select "Part D Information for Pharmaceutical Manufacturers."

MEDICARE AUDIT AND RECORD RETENTION REQUIREMENTS

Pharmacies and their downstream contracted entities must comply with Medicare laws, and, regulations and CMS instructions and guidelines. CMS requires that records be maintained for a period of 10 years from the final date of the contract between CMS and the Plan Sponsor or the date of audit completion, whichever is later. The Pharmacy agrees to make its books and other records available in accordance with section 42 CFR 423.505(e)(2) and 42 CFR 423.505(i)(2), which generally states that CMS may inspect, evaluate and audit any books, contracts, records, including medical records and documentation related to CMS's contract with the Plan Sponsors. In addition, the Pharmacy is responsible for notifying EnvisionRx of Pharmacy closures, acquisitions and mergers. Once Envision has been notified of a Pharmacy closure, acquisition or merger, an attestation will be sent to the Pharmacy to attest to the status of the prescription records.

REJECTIONS

Pharmacies will receive rejections for Claims on drugs with the following rejection message if they are not properly listed with the FDA (ANDA, BLA, NDA drugs) or they are properly listed with the FDA but they are not contracted with CMS for participation in the Coverage Gap Discount Program (BLA/NDA drugs):

1. Reject 70-PM Excludes: NDC not FDA listed (ANDA drugs) or Not CMS contracted (BLA/NDA drugs). Based on guidance from CMS, EnvisionRx utilizes the FDA's Comprehensive NDC Structured Product Labeling Data Element File (NSDE) to determine if a drug is considered a valid Part D drug eligible for coverage under the Medicare Part D Program. There are three (3) steps in determining if a drug is eligible for coverage under Medicare Part D:

    - Determine if the drug product is approved by the FDA. In order to verify the approval status of drug products, verification at the NDC level of all NDCs must be confirmed. This is done through matching the specific NDC against the FDA's NSDE file.

    - If a drug product is not correctly listed in the FDA's NSDE file, EnvisionRx is not able to determine that the drug product is approved by the FDA and the reject messaging listed above will be received by the Pharmacy. For everything properly listed, step 2 is followed.

2. Determine if the Drug Product is Licensed Under an ANDA, NDA or BLA
    - CMS issued guidance on May 21, 2010 in a memo regarding administration of the coverage gap discount program. Additional guidance was issued during the CMS Part C & D User Conference Call held on November 3, 2010. Specifically, drugs that have been approved by the FDA under a New Drug Application (NDA) or Biological License Application (BLA) are considered applicable drugs for the coverage gap discount program. All other Part D drugs (drugs approved under an ANDA, compounds, syringes, and other medical supplies associated with the delivery of insulin) are eligible for coverage under Medicare Part D.

    - If the drug product is licensed under an ANDA (these are typically generic products) or is one of the other non-applicable drug products (i.e. insulin syringes), the product is eligible for coverage under Medicare Part D. If the drug product is licensed under an NDA or BLA, step 3 is followed.

3. Determine if the Drug Product is Made by a Manufacturer who has a Signed Agreement with CMS to Provide the 50% Coverage Gap Discount
    - All manufacturers of applicable drugs must have signed agreements with CMS in order to be considered covered Part D drugs. If the manufacturers did not sign agreements with CMS to provide the coverage gap discount, those drugs are NOT eligible for coverage under any phase of the Medicare Part D benefit. CMS maintains a list of manufacturers that have signed agreements and their applicable labeler codes. This list is then used to verify that drugs properly listed in the FDA NDC Directory with an application type of NDA or BLA is a drug product that is made by a participating manufacturer and therefore considered a valid Part D Drug if the drug is on the Part D Plan's Formulary.

If the drug product is licensed under an NDA or BLA but the manufacturer is not considered a participating manufacturer, then the drug product is not eligible for coverage under Medicare Part D and the reject message stated above will be received by the Pharmacy.

4. Reject 70-PM Excludes; NDC not FDA Listed (ANDA drugs) or Not CMS Contracted BLA/NDA drugs)

It is our recommendation to try to fill the prescription with another NDC for the product. Oftentimes, an alternative manufacturer is listed appropriately in the FDA's NSDE file. If a prescription is filled with an NDC properly listed in the FDA's NSDE file the Claim will pay. Please contact our Pharmacy Help Desk at the number provided in the rejected Claim messaging, if assistance is needed in identifying an NDC that is properly listed with the FDA (TTY Users may call 711).

If you are filling for a brand medication and receive this rejection message, it is our recommendation that you contact the physician for a generic alternative or a branded alternative produced by a participating manufacturer.[1]

PART D UNIQUE BIN REQUIREMENTS

Effective January 1, 2012, CMS required Claims for the Medicare Part D program be submitted through a unique BIN/PCN combination. This is to ensure that (1) Pharmacies can routinely identify situations in which they are billing a Part D Claim and (2) that payers secondary to Part D can properly coordinate benefits on Part D Claims. EnvisionRx has a dedicated BIN/PCN for Medicare Part D Claims 012312/PARTD. In the event a Claim is submitted for medications that are eligible for Medicare Part B coverage for MA-PD Plan Sponsors, Pharmacies will receive the following reject message:

Reject 01: FORCEREJCODE: 01 Invalid BIN. Medicare Part B Drugs must be submitted to BIN/PCN: 009893 / ROIRX

Claims should then be re-submitted using the same Member identification number to the 009893 BIN.[2]

TRANSITION REQUIREMENTS

Medicare Part D requires that a transition process be maintained with respect to: (1) the transition of new Members into prescription drug plans following the annual coordinated election period; (2) the transition of newly eligible Medicare Members from other coverage into a Part D plan; (3) the transition of individuals who switch from one Part D plan to another after the start of the contract year; (4) new Members residing in long term care (LTC) facilities; (5) current Members affected by negative formulary changes from one contract year to the next; (6) Members who request an exception but there is a failure to issue a timely decision on the request by the end of the transition period; (7) Members who remain in the same plan for the new plan year and are on a drug that was the result of an exception that was granted in the previous plan year; (8) current Members experiencing a level of care change; (9) current Members entering the LTC setting from other care settings; and (10) current Members in a LTC setting requiring an emergency supply of a non-formulary drug.

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[1] *Resources/Further Information:* FDA NDC Directory http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm
FDA NDC Directory FAQs http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm
FDA Orange Book http://www.fda.gov/cder/ob/default.htm
FDA Orange Book FAQs http://www.accessdata.fda.gov/scripts/cder/ob/faqlink.cfm
Medicare Prescription Drug Benefit Manual, Chapter 6 - Part D Drugs and Formulary Requirements
http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf
CMS Memo - Medicare Coverage Gap Discount Program Beginning in2011: Revised Part D Sponsor Guidance and Responses to Summary Public Comments on the Draft Guidance
http://www.fdalawblog.net/files/link-12.pdf

[2] *Resources/Further Information:* Further CMS Guidance and Information regarding unique BIN requirements can be found at the following locations: CMS Memo- Clarification of Unique BIN (or BIN/PCN) Requirements as of January 1, 2012
http://www.cms.gov/PrescriptionDrugCovContra/Downloads/HPMSClarificationofUniqueBINRequirements_110810.pdf and
CMS 2102 Combined Call letter- http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Announcement2012final2.pdf

Transition process requirements will be applicable to both non-formulary drugs and drugs on the formulary with utilization management edits, meaning both: (1) Part D Covered Drugs that are not on the applicable Plan Sponsor formulary, and (2) Part D Covered Drugs that are on the applicable Plan Sponsor formulary but require prior authorization or step therapy under Plan Sponsor's utilization management rules.

The EnvisionRx online System will automatically provide up to a temporary 30 day fill in the retail setting (unless the Member presents a prescription written for less than 30 days, in which case EnvisionRx will allow multiple fills to provide up to a total of 30 days of medication) anytime within the first 90 days of the Member's enrollment in a plan, beginning on the Member's effective date of coverage with the Plan Sponsor.

To the extent that a Member is outside his or her 90-day transition period, EnvisionRx will still provide an emergency supply of Part D covered non-formulary medications (including Part D Covered Drugs that are on a Plan Sponsor's formulary that would otherwise require prior authorization or step therapy under Plan Sponsor's utilization management rules). This will occur on a case by case basis, when it has been identified that the Member's exception request or appeal has not been completed by the end of the transition period. Pharmacies should contact the EnvisionRx Pharmacy Help Desk at the number listed on the rejected Claim messaging to obtain emergency transition fills in the retail setting (TTY Users may call 711).

In the long term care (LTC) setting, EnvisionRx online System will automatically provide up to a 98 day supply of medications eligible for transition fills (unless the Member presents with a prescription written for less than 31 days), with multiple refills as necessary, during the first 90 days of a beneficiary's enrollment in a plan, beginning on the Member's effective date of coverage. Pharmacy Network providers are required to place a service location code of 0 or 1 on the Claim and a patient residence code of 03 for NCPDP D.0 submissions in order for the automatic LTC transition process to work correctly. Members in assisted living facilities will be able to obtain up to a 31 day transition fill (instead of 30) when Pharmacy Network providers submit a patient residence code of 4 on a NCPDP D.0 Claim.

In the LTC setting, after the 90 day transition period has expired, EnvisionRx will still provide a 31 day emergency supply of Part D covered non-formulary medications, as well as Part D Covered Drugs that are on a Plan Sponsor's formulary that would otherwise require prior authorization or step therapy under a Plan Sponsor's utilization management rules (unless the Member presents with a prescription written for less than 31 days), while an exception or prior authorization is requested or when it has been identified that the Member's exception request or appeal has not been completed by the end of the transition period. Pharmacies should contact the Pharmacy Help Desk at the number provided in the rejected Claim messaging to obtain an emergency transition fill (TTY Users may call 711).

For Members being admitted to or discharged from a LTC facility, early refill edits will not be used to limit appropriate and necessary access to their Part D benefit, and such Members are allowed to access a refill upon admission or discharge.

In the event a prescription is for a pack size that due to dosing requirements exceeds the 30 day transition fill rule (i.e. eye drops or insulin) and the pack size cannot be broken to provide only the 30 day supply, Pharmacies should contact the Pharmacy Help Desk at the number provided in the rejected Claim messaging to obtain a manual transition override (TTY Users may call 711).[3]

[3] *Resources/Further Information:* http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoTransitionReminder_082710.pdf

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS – REVISED GUIDANCE FOR DISTRIBUTION OF STANDARDIZED PHARMACY NOTICE (CMS-10147)

As required by CMS guidelines, Medicare Part D Network Pharmacies (including Mail-Order and Specialty Pharmacies) are required to distribute a written copy of the standardized Pharmacy Notice when the Member's prescription cannot be covered ("filled") under the Medicare Part D benefit and the issue cannot be resolved at point of sale. The Pharmacy Notice instructs Members about their right to contact their Part D plan to request a coverage determination, including an exception. This is a standardized Pharmacy Notice, the content of which may not be altered. The Office of Management and Budget (OMB) control number must be displayed in the upper right corner of the notice. The fields for the Member's name, drug and prescription number are optional and may be populated by the Pharmacy. A logo is not required but Pharmacies may place their logo in the space above the optional fields for the Member's name, drug and prescription number. The Pharmacy Help Desk can be contacted at 800-361-4542 with questions, or if the required attestation has not been returned to EnvisionRx (TTY Users may call 711).

Printing the Pharmacy Notice on prescription label stock or an integrated prescription receipt is permitted, so long as the Pharmacy Notice is provided to the Member in at least 12-point font. Electronic distribution of the Pharmacy Notice is permitted if the Member or the Member's appointed representative has provided an e-mail address or fax number and has indicated a preference for that method of communication.

Mail-Order Pharmacies

If a prescription cannot be covered ("filled") under the Medicare Part D program as described above, the Mail Order Pharmacy must distribute the standardized Pharmacy Notice to the Member. The Mail Order Pharmacy has the option of working with the plan and the prescriber to resolve the matter and provide the needed medication or an appropriate substitute. If the matter cannot be resolved and the Pharmacy cannot fill the prescription, the Pharmacy Notice must be provided to the Member via the Member's preferred method of communication (fax, email, or first class mail) as expeditiously as the Member's health condition requires, but no later than 72 hours from the Pharmacy's receipt of the original transaction response indicating the Claim is not covered by Medicare Part D.

Home Infusion Pharmacies

If a prescription cannot be covered ("filled") under the Medicare Part D program as described above, the home infusion Pharmacy must distribute the standardized Pharmacy Notice to the Member either electronically, by fax, in-person, or by first class mail. The home infusion Pharmacy has the option of working with the plan and the prescriber to resolve the matter and provide the needed medication or an appropriate substitute. If the Pharmacy cannot fill the prescription, the Pharmacy Notice must be provided to the Member expeditiously as the Member's health condition requires. However, no later than 72 hours from the Pharmacy's receipt of the original transaction response indicating the Claim is not covered by Medicare Part D. For Member brought on service by the home infusion Pharmacy, the Pharmacy can also choose to deliver the Pharmacy Notice in person with delivery of home infusion drugs or through an infusion nurse if the next scheduled visit is within 72 hours of the receipt of the transaction code indicating the Claim cannot be covered by Medicare Part D.

Reminder of the Part D Transition Policy
http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoTransitionReminder_082710.pdf
Final 2007 Transition Guidance- http://www.cms.gov/PrescriptionDrugCovContra/downloads/CY07FinalTransitionChangesDocument.pdf

NPPES Registration

Pharmacy must maintain the CMS required specialty registration and identification as a home infusion provider through National Plan & Provider Enumeration System (NPPES). Failure to maintain such self-reported registration and identification may result in reimbursement withholds or reductions and/or recovery of paid Claims amounts by Network on behalf of its Plan Sponsors, unless or until all Pharmacy primary and additional specialty(ies) registration requirements have been met.

NOTE: Network reserves the right to audit Claims and related documentation of Pharmacy on behalf of its Plan Sponsors to ensure compliance with the PPA as a home infusion Pharmacy.

Pharmacies Serving Long Term Care Facilities

Given the uniqueness of the long term care (LTC) setting, there is typically no point of sale encounter between the Pharmacy and the Member (LTC resident) and, therefore, no practical means for the Pharmacy to provide the Pharmacy Notice directly to the Member. In most instances where there is an issue with the prescription, CMS expects that the pharmacist will contact the prescriber or an appropriate staff person at the LTC facility to resolve the matter. This will ensure the Member receives the needed medication or an appropriate substitute, obviating the need to deliver the Pharmacy Notice. If the Pharmacy must fax or otherwise deliver the Pharmacy Notice to the Member, the Member's representative, prescriber or an appropriate staff person at the LTC facility must receive the Pharmacy Notice expeditiously as the Member's health condition requires. However, no later than 72 hours from the Pharmacy's receipt of the original transaction response indicating the Claim is not covered by Part D.

NOTE: If the Member is a self-pay resident, and the Pharmacy cannot fill the prescription under the Part D benefit, the Pharmacy must, upon receipt of the transaction response, fax, or otherwise deliver the Pharmacy Notice to the Member, the Member's representative, prescriber or an appropriate staff person at the LTC facility. After distribution of the Pharmacy Notice, the LTC Pharmacy should continue to work with prescriber or facility to resolve the matter and ensure the resident receives the needed medication or an appropriate substitute. [4]

EnvisionRx will provide Network Pharmacies a primary reject code for the following reasons:

1. Reject 70: Non Formulary Medications
2. Reject 75: Prior Authorization or Step Therapy Required
3. Reject 9G: Quantity Dispensed Exceeds Maximum Allowed

[4] Resources/Additional Information: NCPDP website
http://www.NCPDP.org/
Medicare Prescription Drug Coverage and Your Rights
CMS Memorandum on Revised Guidance for Distribution of Standardized Pharmacy Notice (CMS-10147) to Medicare Advantage Organizations and Medicare Prescription Drug Plan Sponsors dated December 27, 2012, *available at* www.envisionrx.com

In addition, EnvisionRx will transmit a secondary Reject Code 569. Per NCPDP, this rejection code is defined as: "Provide Beneficiary with CMS Notice of Appeal Rights". This secondary reject code will tell Pharmacies that a Pharmacy Notice is required to be distributed to the Member. The Pharmacy Help Desk can be contacted at the number listed on the rejected Claim messaging (TTY Users may call 711).

The Notice of Appeal Reject Code will not be returned in circumstances where transition coverage would not apply, such as:

1. The Claim does not contain all necessary data elements for adjudication
2. The drug in question is an over-the-counter (OTC) medication that is not covered by a Plan Sponsor
3. The prescription is written by a sanctioned provider who has been excluded from participation in the Medicare Program
4. The drug is not listed on the participating CMS Manufacturer Labeler Code List
5. The drug is not listed on the Food and Drug Administration (FDA) Electronic List-NDC Structured Product Labeling Data Elements File (NSDE)
6. The Claim rejects for a refill too soon/early refill edit
7. The drug in question is not covered by the Part D plan benefit, but is covered by a co-administered insured benefit managed by a single processor. In this scenario, the Pharmacy submits a single Claim transaction for the drug and drug is covered by the co-administered insured benefit after being rejected by Part D and processed in accordance with the benefits offered by the supplemental payer.
8. The drug is excluded from coverage under Medicare Part D (i.e. drugs used for cosmetic purposes, drugs used for weight loss or gain, drugs used to promote fertility, drugs used for the symptomatic relief of cough & cold symptoms, prescription vitamins or mineral products except for prenatal vitamins or fluoride preparations, or drugs used to treat erectile dysfunction)
9. The drug requires a Medicare Part B vs. Medicare Part D determination

Additional copies of the Medicare Prescription Drug Coverage and Your Right Standardized Pharmacy Notice are available from the EnvisionRx Network Compliance Department as well as the CMS website.[5]

HOSPICE MEDICATIONS

CMS requires that Part D Plan Sponsors ensure that Part D does not pay for drugs and biologics that may be covered under the Medicare Part A per-diem payment to a hospice program. As specified in Section 1861(dd) of the Social Security Act and in federal regulations at 42 CFR 418, the hospice provider is responsible for covering all drugs or biologics for the palliation and management of the terminal and related conditions.

Please note CMS' position is stated in the 1983 Hospice Final Rule, which implemented the hospice benefit.

CMS interpreted related conditions broadly, and wrote that hospices are required to cover virtually all the palliative care needed by terminally ill patients (48 FR 56010). Drugs for the palliation and management of the terminal illness and related conditions are the responsibility of the hospice, and as CMS has noted in rulemaking, at the end of life, most conditions are related.

[5] Resources/Additional Information:
Medicare Prescription Drug Coverage and Your Rights
http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/yourrightsfactsheet.pdf

Thus, when a sponsor receives a transaction reply report (TRR) showing a Member has elected hospice, the sponsor must have controls in place to comply with this requirement. Plan Sponsors are encouraged to place beneficiary-level PA requirements on four categories of prescription drugs, including: analgesics, antinauseants (antiemetics), laxatives, and antianxiety drugs.

Effective 09/01/2013, and monthly thereafter, EnvisionRx will be implementing Member level prior authorization for the above four categories of medications for all Member who have elected hospice coverage as identified via Medicare eligibility data.

Your Pharmacy may start seeing rejections on drugs previously covered under the Part D benefit. Reject messaging will state: "Per Medicare enrollment – Member in hospice. Please bill hospice provider. If Member is no longer on hospice please call 866-250-2005."

In addition, once the edits are in place for current Member EnvisionRx will be notifying all Pharmacies with prior Claims for these Member' to ask that the Claims to be reversed and billed to the hospice provider. EnvisionRx will send the hospice provider contact information to the Pharmacy if we have it available. [6]

PRESCRIBER VERIFICATION

CMS guidance specifies that the NPI is intended to uniquely identify a health care provider in standard transactions, such as health care Claims. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use NPIs in standard transactions by the specified compliance dates. The NPI is the only health care provider identifier that covered entities may use to identify health care providers.

Per CMS final rule (77 FR 54664), beginning May 6, 2013, Type I (Individual) NPIs are to be submitted on Claims. As per this requirement, any Type 2 (Organizational) NPI submitted by the Pharmacy will be rejected at point of sale with a force Reject Code 619. EnvisionRx will only accept Claims for a valid Type I Prescriber NPI.

EnvisionRx subscribes to a service that maintains Prescriber NPI and DEA numbers, as well as the scope of practice with respect to authority to prescribe controlled substances. This database is updated bi-weekly. During the electronic submissions, if the prescriber is not found within the database or has an expired or invalid DEA or NPI, the Claim will reject.

CMS will allow rejections on these Claims as long as they can be resolved at point of sale. If your Pharmacy receives a reject 619 (Rejection 619: Prescriber Type 1 NPI Required; Effective 5.6.2013 A valid Individual Prescriber NPI is required on all Claims. Organizational NPIs no longer permitted), please take the following steps to attempt to obtain a paid Claim.

Verify that the correct prescriber NPI/DEA number has been entered on the Claim

- If previously submitted an incorrect NPI/DEA number, correct the number and resubmit the Claim
- If still receiving a reject, please verify that the NPI/DEA submitted does not belong to an organization. If so, correct the number and resubmit the Claim.

If Pharmacy submitted the correct prescriber NPI/DEA number on the Claim and the NPI is not a Type II

[6] CMS 2014 for Medicare Advantage Call Letter for 2014 Hospice Drug Policy - *http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Advance2014.pdf*

- Verify that the physician name is spelled correctly
- Verify you have the physician address and phone number entered correctly

Please contact the EnvisionRx Pharmacy Help Desk at 800-361-4542, if you have questions or require additional assistance. (TTY users may call 711).[7]

LONG TERM CARE PHARMACY (LTC)

If the Pharmacy is located in, or has a contract with, a LTC facility, and the Member is in a LTC facility, the Pharmacy has up to 90 days from the date of dispensing to submit a Claim for reimbursement.

SHORT CYCLE DISPENSING

Pursuant to CMS 42 CFR 423.154, beginning January 1, 2013 and thereafter, to the extent that long term care (LTC) Pharmacies dispenses Oral Solid Brands to Member residing in long term care facilities, LTC Pharmacy shall dispense only Short Cycle Drug Doses of an Oral Solid Brand, regardless if the Oral Solid Brand is written for an amount exceeding a 14 day supply by a prescriber.

"Oral Solid Brand" or "Oral Solid Brand Name Maintenance Covered Product" means a brand name prescription drug that is a prescription product as defined in CMS 42 CFR 423.4. Excluded from the definition of Oral Solid Brand name prescription drugs as defined at CMS 42 CFR 423.154(b) include prescription drugs such as, but not limited to, solid oral doses of antibiotics and solid oral doses of prescription drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging (e.g., oral contraceptives).

Your Pharmacy may receive rejections on drugs you believe are generic. Below is an excerpt from the Medicare Prescription Drug Benefit Manual which explains when Medicare considers a drug a generic medication under the Medicare Part D program.

> "… (f)or a purpose of Part D, what determines whether a drug is a generic drug is the type of application on file for that product with the Food and Drug Administration (FDA). If a drug product approval is based upon an abbreviated new drug application (ANDA), that drug is therefore a generic drug."(42 CFR 423.4)

If your Pharmacy has received a Claim rejection and would like to verify drug application type on file with the FDA, please reference http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm or at: http://www.fda.gov/ForIndustry/DataStandards/StructuredProductLabeling/ucm240580.htm

As set forth in the CMS requirement, announced changes to the Drug Data Processing System (DDPS) for the purpose of using prescription drug event (PDE) data as a vehicle for meeting the regulatory reporting requirements described at 42 CFR 423.154(a)(2). Health care providers, such as a hospital, must require certain non-covered individual health

[7] Resources/Additional Information:
CMS 2102 Combined Call letter *http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Announcement2012final2.pdf*
CMS Memo-Prescriber Identifier Reporting
CMS Memorandum on Modifications to the Drug Data Processing System (DDPS) in Relation to Appropriate Dispensing of Prescription Drugs in Long-Term Care Facilities dated August 3, 2012, *available at www.envisionrx.com*

care providers who are prescribers to obtain and disclose a NPI. The compliance date for the new NPI requirement is May 6, 2013. Sponsors must report only a Type 1 (individual) NPI on the PDE record.

As instructed, beginning February 28, 2013 CMS will revise the PDE detail record layout to include Pharmacy Service Type (147-U7), Patient Residence (384-4X), and Submission Clarification Code (420-DK). Below are the fields' Definition and Values effective November 2012. For those Claims where the Patient Residence is 03—Nursing Facility, the Submission Clarification Code (SCC), if applicable, must also be valid.

FIELD NAME	DEFINITION / VALUES
Pharmacy Service Type	The type of service being performed by a Pharmacy when different contractual terms exist between a payer and the Pharmacy, or when benefits are based upon the type of service performed. 01 – Community/Retail Pharmacy Services 02 – Compounding Pharmacy Services 03 – Home Infusion Therapy Provider Services 04 – Institutional Pharmacy Services 05 – Long Term Care Pharmacy Services 06 – Mail Order Pharmacy Services 07 – Managed Care Organization Pharmacy Services 08 – Specialty Care Pharmacy Services 99 – Other
Patient Residence	Code identifying the patient's place of residence. 00 – Not specified, other patient residence not identified below 01 – Home Community/Retail Pharmacy Services 03 – Nursing Facility 04 – Assisted Living Facility 06 – Group Home 09 – Intermediate Care Facility/Mentally 11 - Hospice
Submission Clarification Code	Code indicating they the pharmacist is clarifying the submission. 16 – Long Term Care (LTC) emergency box or automated dispensing machine 21 – LTC dispensing, 14 days or less not applicable 22 – LTC dispensing, 7 day supply 23 – LTC dispensing, 4 days 24 – LTC dispensing, 3 day 25 – LTC dispensing, 2 day 26 – LTC dispensing, 1 days 27 – LTC dispensing, 4 day, then 3 day supply 28 – LTC dispensing, 2 day, then 3 day supply 29 – LTC dispensing, daily during the week then multiple days for weekend 30 – LTC dispensing, per shift 31 – LTC dispensing, per med pass 32 – LTC dispensing, PRN on demand 33 – LTC dispensing, other 7 day or less cycle 34 – LTC dispensing, 14 day supply

	35 – LTC dispensing, 8-14 day dispensing not listed above 36 – LTC dispensing, outside short cycle, determined to be Medicare Part D after originally submitted to another payer

2014 REQUIREMENTS FOR CODING PATIENT RESIDENCE AND PHARMACY SERVICE TYPE ON CLAIM TRANSACTIONS

On June 20, 2013, CMS released a memo regarding the 2014 Requirements for Patient Residence and Pharmacy Service Type on Claims transactions. Beginning in 2014, CMS will require a valid Patient Residence and Pharmacy Service Type on all Medicare Part D Claims. All Retail and Mail Order Pharmacies must include a valid Patient Residence code on all Part D Claims transactions. If the patient residence is unknown, the Pharmacy may default to a Patient Residence of 1 (Home). Long term care, home infusion, and Specialty Pharmacies should be able to reliably report on all Claims since they deliver to the Member residence. In the event a transaction has a missing or invalid code, the Claim may be rejected at point-of-sale.

Valid Patient Residence Codes:

0 – Not specified other patient residence not identified below
1 – Home
3 – Nursing Facility
4 – Assisted Living Facility
6 – Group Home
9 – Intermediate Care Facility/Mentally Retarded
11 – Hospice

All Pharmacies are expected to know the appropriate (i.e., non-default) Pharmacy service code to include on all Part D Claims.

Valid Pharmacy Service Type Codes:

1 – Community/Retail Pharmacy Services
2 – Compounding Pharmacy Services
3 – Home Infusion Therapy Provider Services
4 – Institutional Pharmacy Services
5 – Long Term Care Pharmacy Services
6 – Mail Order Pharmacy Services
7 – Managed Care Organization Pharmacy Services
8 – Specialty Care Pharmacy Services
99 - Other

*Network reserves the right to audit Claims on behalf of its Plan Sponsors. Failure by Pharmacy to submit Claims with proper submission codes may result in reimbursement withholds or reductions and/or recovery of paid Claims amounts, unless or until all correct submission code requirements have been met.

2014 DAILY COST SHARING REQUIREMENTS

Beginning, January 1, 2014, certain prescriptions that are dispensed by a participating Pharmacy for less than a 30 days' supply may have an applicable daily Cost Sharing rate attached in accordance with 42 C.F.R. § 423.153(b)(4)(i). This requirement provides Part D Member, in consultation with their prescribers, the option of shorter days' supplies of initial fills of new prescriptions without the disincentive of the Member paying a full month's co-payment or coinsurance.

Prescribers are expected to be particularly supportive of this prescribing option when the prescription is for a drug that has significant side effects, is frequently poorly tolerated, and when less than a month's supply of the prescription is clinically appropriate.

In addition, it would allow the Member the ability to synchronize their prescriptions in consultation with their pharmacists without having to pay a full month's Cost Share when less than a month's supply of medication(s) is dispensed during the synchronization process until all medications are on the same thirty or more days refill schedule. CMS intends to include language in future Medicare & You and Part D Evidence of Coverage (EOC) documents on the availability of daily Cost Sharing rates, and on how beneficiaries should consider taking advantage of them. Also, it should be noted that daily Cost Sharing requirements does not address how Pharmacy dispensing fees are to be negotiated, calculated or paid. There is no necessary connection between daily Cost Sharing amounts charged to beneficiaries and how dispensing fees are paid to Pharmacies. [8]

ADDITIONAL MEDICARE PART D REQUIREMENTS

1. True Out Of Pocket ("TrOOP")
   Your Pharmacy must process TrOOP expenses as required by CMS. Pricing information will be communicated back to the Pharmacy via the online System.

2. Cost Sharing
   Your Pharmacy must charge and apply the correct Member Cost Share amount, including that which applies to the Member qualifying for the low-income subsidy. Cost Share amounts will be communicated back to the Pharmacy via the online System. Your Pharmacy must also, if expressly requested by the Part D Member, agree to not submit the Claim to the payer.

3. Pricing Differential
   Your Pharmacy must inform Medicare Part D Member at the point of sale (or at the point of delivery) of the lowest priced, generically equivalent drug if one exists for the Member's prescription, as well as an associated differential in price. (Member's copayments are often based on whether a generic, preferred brand or non-preferred brand is dispensed.) Prescription drug costs can best be managed through the following actions:

   - Generic Drug Substitution – Dispense FDA-approved generic equivalent drugs whenever possible and in accordance with federal and state laws. Contact the prescriber if necessary in order to dispense a generic equivalent drug. Certain drugs with documented dosing problems should not be dispensed generically unless requested by the prescriber.
   - Prescription Drug List Compliance – If a generic equivalent drug cannot be substituted, contact the prescriber to determine if a drug from the Prescription Drug List can be dispensed as an alternative. Claims messaging will usually contained the preferred drug alternative.
   - Prescriber "Dispense as Written" Prescription (DAW1) – If a prescription specifies "Dispense as Written," Pharmacy should contact the prescriber to determine if a generic equivalent or drug from the Prescription Drug List can be dispensed as an alternative.

[8] Resources/Additional Information:
CMS Memorandum on 2014 Requirements for Coding Patient Residence and Pharmacy Service Type on Claims dated June 20, 2013, *available at www.envisionrx.com*

4. Compliance

Your Pharmacy is required to fill prescriptions, provide reporting, and provide all services required to support the Medicare Prescription Drug Benefit Program, and to abide by all applicable federal and state laws and regulations, as well as CMS instructions.

5. Home Infusion Pharmacies

"All home infusion Pharmacies shall, at a minimum, meet the following requirements:

(i) Are capable of delivering home-infused drugs in a form that can be administered in a clinically appropriate fashion.

(ii) Are capable of providing infusible Part D drugs for both short-term acute care and long-term chronic care therapies.

(iii) Ensure that the professional services and ancillary supplies necessary for home infusion therapy are in place before dispensing Part D home infusion drugs.

(iv) Provide delivery of home infusion drugs within 24 hours of discharge from an acute care setting, or later if so prescribed.

in accordance with CMS § 423.120 Access to Covered Part D Drugs. "

6. e-Prescribing

If the Pharmacy transmits and/or receives prescription and prescription related information using electronic media for Part D Covered Drugs for Part D eligible individuals, Pharmacy must comply with all *e*-prescribing standards, using current NCPDP standards.

7. Minimum Standards

Your Pharmacy is required to comply with the applicable minimum standards for Pharmacy practice as established by the state in which the Pharmacy is located.

8. Payment of Clean Claims

In accordance with 42 CFR 423.520, your Pharmacy will be reimbursed within 14 days of submission date for all clean Claims submitted via the online System, and within 30 days for other Claims (e.g. rejected or disputed Claims etc.).

VACCINES

The purpose of the EnvisionRx Pharmacy Vaccine Program is to provide a range of vaccines that may be appropriately administered in the Pharmacy setting. The fee schedule is listed at the Generic Product Indicator (GPI) level, allowing Pharmacies the flexibility to purchase various NDCs within that GPI. EnvisionRx may modify the list of GPIs below from time to time to accommodate industry availability. For the GPI's listed below, Pharmacies are eligible to receive a

vaccine administration fee.

State laws may vary regarding administration of some vaccines at a Retail setting or by a pharmacist. You are required to know and comply with your state's regulations regarding the administration of vaccines by your Pharmacy.

RETAIL VACCINE PROCESSING INSTRUCTIONS

In order for your Pharmacy to be reimbursed correctly, please submit Claims as you would normally with the NDC code. You must submit quantity dispensed (i.e. one vial is submitted as quantity 1, regardless of mL dose) in the "Metric Decimal or Quantity Dispensed" field which appears as FIELD # 442-E7 on your Payer Sheet.

You must submit "MA" in the "Pro Svc Code, Professional Service Code" field which appears as FIELD # 440-E5 on your Payer Sheet. The administration fee must go in the "Incent Amt Sub, Incentive Amount Submitted" field which appears as FIELD # 438-E3 on your Payer Sheet.

In order to receive a vaccine under this program, Members should present their Member ID Card to the pharmacist. The BIN/PCN will be the same as submitted for Commercial, Medicare, or Medicaid Claims. The Pharmacy is contractually obligated to collect any applicable copays or Cost Sharing. Please note that not all EnvisionRx Plan Sponsors participate in this program.

VACCINE PROGRAM LIST

GPI	Name
INFLUENZA VACCINES	
1710002021E620	Afluria Preservative Free
17100020201800	Afluria
1710002046E620	Fluad
17100020852000	Flublok
1710002086E520	Flublok Quadrivalent Preservative Free
1710002082E620	Flucelvax Quadrivalent
17100020821800	Flucelvax Quadrivalent
17100020541800	FluMist Quadrivalent
1710002040E605	Fluvirin
17100020401800	Fluvirin
1710002023E620	Fluzone HD Preservative Free
17100020251820	Fluzone Quadrivalent INJ 2018-2019
1710002025D310	Fluzone Quadrivalent Intradermal
1710002025E620	Afluria, Flulaval, Fluzone, & Fluarix Quadrivalent Preservative Free
17100020251800	Flulaval & Fluzone Quadrivalent

GPI	Name
1710002025E610	Fluzone Quadrivalent Pediatric dose Preservative Free
ADDITIONAL VACCINES	
17200030102100	ActHIB
18990003221815	Adacel
1720004015E620	Bexsero
18990003221820	Boostrix
18990003201830	Daptacel
18990002101810	Diphtheria/Tetanus Toxoi
17100010201827	Engerix-B
17100010201830	Engerix-B
17100010202210	Engerix-B
17100010202230	Engerix-B
17100065101820	Gardasil
17100065501800	Gardasil 9
1710006550E600	Gardasil 9
17100008001830	Havrix
17100008001840	Havrix
17100010302020	Heplisav-B
1710001030E520	Heplisav-B
17200030102122	Hiberix
18990003201840	Infanrix
17100050002250	IPOL
18990004351820	Kinrix
17200040442200	Menactra
17209902502120	MENHIBRIX
17200040482100	Menveo
17109903102200	M-M-R II
18990005501820	Pediarix
17200030101820	PedvaxHIB
18990005301920	Pentacel
17200065002205	Pneumovax 23
17200065301800	Prevnar 13
17109904202200	ProQuad
17100010201815	Recombivax HB
17100010201820	Recombivax HB

GPI	Name
17100010201840	Recombivax HB
17100075001920	Rotarix
17100075102020	RotaTeq
18990002202210	Tenivac
17100095401920	Shingrix
18990002201805	Tetanus-Diphtheria Toxoids (Td)
1720004012E610	Trumenba
17109902051820	Twinrix
17100008001860	Vaqta
17100008001870	Vaqta
17100087102210	Varivax
17100095101920	Zostavax

PRICING AND REIMBURSEMENT QUESTIONS

The Pharmacy Help Desk is open for questions regarding payment and pricing 24 hours a day, 7 days a week, 365 days a year. If you feel that you have not been properly reimbursed for a prescription drug, please call the Pharmacy Help Desk at 800-361-4542 to speak with a Customer Service Representative (TTY users may call 711). Please provide your Pharmacy's NCPDP number, prescription number, date of service, NDC number of the drug, quantity dispensed and the amount due your Pharmacy. The representative will log the details and forward the disputed Claim over to the appropriate team for review and follow up.

Please be advised that if your Pharmacy submits a Claim to EnvisionRx, even if your Pharmacy is not currently contracted at the time of service, for a program, your acceptance for reimbursement constitutes acceptance of the rates for that program.

EnvisionRx contracts for rebates and provides the discount price that is to be compared with your Usual and Customary Price. The lower of the two prices is sent back to the Pharmacy as the amount to be paid to the Pharmacy.

In the event that EnvisionRx determines that your Pharmacy was overpaid or underpaid for a prescription, the adjusted amount will be applied to your next reimbursement cycle. Your Pharmacy must continue to dispense prescriptions to Members in good faith during and subsequent to any pricing and reimbursement. Your Pharmacy must refrain from making disparaging comments to Members about EnvisionRx or about Member's health care plan or program.

MAXIMUM ALLOWABLE COST (MAC)

MAC Lists

MAC pricing is available to Pharmacies upon request via calling the Help Desk at 1-800-361-4542 or emailing MAC@envisionrx.com. MAC pricing lists will be reviewed and updated at least every 7 business days to reflect changes in pricing data. If there is a conflict with EnvisionRx's standard for updating the MAC price lists and an applicable state law or regulation, EnvisionRx will follow the stricter provision.

Maximum Allowable Cost Appeals

Pharmacies may contact EnvisionRx with MAC concerns at MAC@envisionrx.com or through the EnvisionRx Help Desk at 1-800-361-4542. EnvisionRx requests that the Pharmacies provide the below information to ensure the requests can be reviewed without any disruption: Rx BIN, Group ID, Rx Number, Date of Fill, NDC, Drug and Strength, Quantity Dispensed, NCPDP Number, Acquisition Cost and Contact Name and Number.

Upon receipt of the required Claim information, EnvisionRx will complete market research utilizing nationally recognized wholesalers to determine the Independent Pharmacy purchasing price. This price will be compared to the current MAC price to determine if an adjustment is needed. Should an update in price be needed, EnvisionRx will update the MAC price within 5 business days. If an appeal price is deemed valid and supported by market research, a response back to the Pharmacy will include the reason for denial and if necessary based on the appeal, the NDC for the lower cost product which substantiates the MAC price. Appeals will be responded to within 7 business days. If there is a conflict with EnvisionRx's standard for addressing MAC appeals and an applicable state law or regulation, Envision will follow the stricter provision.

STATE SPECIFIC PROVISIONS

NEW HAMPSHIRE - MEDICAID LINE OF BUSINESS

Participating Pharmacies must comply with the following provisions in connection with the New Hampshire Medicaid Care Management Program. Said provisions are subject to DHHS' approval and revisions.

Pharmacy's Licensure and Enrollment. Pharmacy represents and agrees that it is licensed and/or certified in accordance with the laws of the State of New Hampshire, and Pharmacy is not excluded from participation in federal health care programs or under sanction or exclusion from participation in the New Hampshire state Medicaid program. Pharmacy further represents and agrees that it is enrolled as a New Hampshire Medicaid provider. Pharmacy agrees to notify Network immediately should Pharmacy be excluded from participation in federal health care programs or be sanctioned or excluded from the New Hampshire state Medicaid program.

I. **Pharmacy's Acceptance of – and Compliance with – all Eligibility and Reporting Requirements.** Pharmacy represents and agrees that it is in compliance with all federal and state eligibility criteria, reporting requirements, and any other applicable rules and regulations related to the New Hampshire state Medicaid program.

II. **Pharmacy's Acceptance of – and Compliance with – Federal and State Statutes and Regulations.** Pursuant to 42 CFR 438.6, 42 CFR 438.100(a)(2) and 42 CFR 438.100(d), Pharmacy agrees to adhere to all applicable federal and state laws, including the following without limitation:

A. Pharmacy shall ensure that at a minimum, conflict of interest safeguards equal to federal safeguards (as set forth at 41 USC 423, section 27) are in place (as set forth in Social Security Act, Section 1923(d)(3)).

B. Pharmacy shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

   i. Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. §1395 et seq.

   ii. Related rules: Title 42 Chapter IV

   iii. Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. §1396 et seq. (specific to managed care: §§ 1902(a)(4), 1903(m), 1905(t), and 1932 of the Social Security Act)

   iv. Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR § 438; see also 431 and 435)

   v. Children's Health Insurance Program (CHIP): Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397; Regulations promulgated thereunder: 42 CFR 457

   vi. Patient Protection and Affordable Care Act of 2010

   vii. Health Care and Education Reconciliation Act of 2010, amending the Patient Protection and Affordable Care Act

   viii. American Recovery and Reinvestment Act

   ix. 42 CFR 435; XX-YY, Chapter ZZ of New Hampshire Department of Health and Human Services' ("DHHS") Eligibility Manual, NH Laws (RSAs), Regulations, State Plan

C. Pharmacy shall meet Medicare certification and be in good standing. Pharmacy represents that it is not, and does not employ or contract, directly or indirectly, with:

   i. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 or 1128A of the SSA for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

   ii. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity;

   iii. Any individual or entity excluded from Medicaid or New Hampshire participation by DHHS;

   iv. Any individual or entity discharged or suspended from doing business with the State of New Hampshire;

v. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act; or

vi. Any providers or subcontractors excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

D. Pharmacy shall comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.

E. Pharmacy shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing Services, Pharmacy will not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid beneficiaries who are qualified disabled individuals covered by the provisions of the ADA. A "qualified individual with a disability" defined pursuant to 42 U.S.C. § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

F. In connection with ensuring non-discrimination in enrollment, Pharmacy agrees:

i. To not discriminate against eligible Medicaid recipients because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

ii. To not discriminate against eligible persons or eligible Medicaid recipients on the basis of their health or mental health history, health or mental health status, their need for health care services, the insurance reimbursement amount based on the eligible person's actuarial class, or pre-existing medical/health conditions.

G. Pursuant to 42 CFR 438.100(c), Pharmacy agrees that each eligible Medicaid recipient is free to exercise his/her rights, and an eligible Medicaid recipient's exercise of those rights shall not adversely affect the way Pharmacy treats the eligible Medicaid recipient.

H. Pursuant to 42 CFR 438.206(c)(1)(ii), Pharmacy agrees to offer to eligible Medicaid recipients hours of operation that are no less than the hours of operation offered to commercial and FFS patients.

I. Pursuant to 42 CFR 438.106(c), 42 CFR 438.6(1), 42 CFR 438.230 and 42 CFR 438.204(a) and Section 1932(b)(6) of the Social Security Act, Pharmacy agrees that it may not bill any eligible Medicaid recipient any amount greater than would be owed if Pharmacy provided the services directly to the eligible Medicaid recipient, and the eligible Medicaid recipient was without any Medicaid or insurance coverage.

J. Pharmacy shall comply with the terms of the Federal False Claims Act, as set forth at 31 U.S.C. §§ 3729 to 3733, and with the New Hampshire False Claims Act, as set forth at N.H. Rev. Stat. Ann §§ 167:61b to e (and as each may be amended from time to time), including the whistleblower protections afforded by such laws.

K. Pharmacy shall comply with the Health Insurance Portability & Accountability Act of 1996 (as governed by 45 C.F.R. Section 164.504(e)), which will be provided on request from Pharmacy.

III. Pharmacy's Acceptance of – and Compliance with –Terms Required by DHHS Medicaid Contract. Pharmacy acknowledges that Boston Medical Center Health Plan, Inc. ("BMCHP" or "Client"), doing business as Well Sense Health Plan in New Hampshire, has entered into a government agency contract with DHHS to manage and arrange for the provision of covered services to New Hampshire Medicaid enrollees ("DHHS Medicaid Contract"); that the term "BMCHP Medicaid Care Management Program" shall mean the Medicaid managed care program offered by BMCHP to New Hampshire Medicaid enrollees pursuant to the DHHS Medicaid Contract; that the DHHS Medicaid Contract contains provisions applicable to participating providers, including Pharmacies; and that Pharmacy agrees to comply with the terms and conditions of the DHHS Medicaid Contract applicable to Pharmacies, including without limitation the requirements reflected in the following:

A. Pharmacy agrees to submit and transmit all Claims information to Network, as directed by Network, so as to satisfy the terms of the DHHS Medicaid Contract.

B. Subject to applicable rules regarding patient confidentiality, Pharmacy shall, within the time required by Network and/or BMCHP, provide Network and/or BMCHP with copies of specified Member' Pharmacy and other relevant records to enable Network and/or BMCHP to meet legal or contractually-imposed requirements, including without limitation, for purposes of resolving Member appeals and grievances. Pharmacy acknowledges that, because of substantial fines and penalties imposed under applicable laws and contracts, timely provision of records under this section is a material obligation of Pharmacy.

C. Network, its designee, or DHHS may conduct an audit pursuant to the DHHS Medicaid Contract or as required by DHHS. Pharmacy shall cooperate with and extend all reasonable and necessary support to Network, its designee, and/or DHHS to facilitate any review or audit.

D. To enable Network and Client to create and update Client's Provider Directory and post accurately all DHHS required information concerning Pharmacy Network providers on a website accessible to participants who are eligible and enrolled in the BMCHP Medicaid Care Management Program ("Member"), Pharmacy agrees to provide Network, in writing, with the following information within twenty four (24) hours of any change to said information: (a) Pharmacy name; (b) Pharmacy location; (c) Pharmacy telephone number(s); (d) Pharmacy office hours; (e) whether Pharmacy offers non-English languages, and if so, which languages are offered; (f) if Pharmacy is not accepting new patients; or (g) any change in restrictions to Member' freedom of choice.

E. Pharmacy agrees to accept a Member's Medicaid ID Card as proof of enrollment until Member receives a BMCHP's Medicaid Care Management Program ID Card.

F. Pharmacy agrees that, in no event, including without limitation, nonpayment by Network or Network's insolvency, shall Pharmacy bill, charge, collect a deposit from, seek payment from, maintain any action at law or in equity or have any other recourse against a Member for items provided pursuant to BMCHP Medicaid Care Management Program. This provision does not prohibit Pharmacy from collecting from Member (i) Copayments or Deductibles consistent with BMCHP Medicaid Care Management Program; or (ii) charges for items not covered under BMCHP Medicaid Care Management Program delivered on a fee-for-service basis to Member who are informed in advance of the cost and agree in writing to accept payment responsibility for such non-covered items.

G. Pharmacy agrees to submit to any periodic Credentialing recertification processes by which client and/or Network periodically review, approve and recertify the credentials of Pharmacy pursuant to NCQA requirements and any comparable requirements defined by DHHS.

H. Pharmacy shall be responsive to the linguistic, cultural and other unique needs of any minority, homeless person, disabled individuals or other special populations that comprise BMCHP's Membership, including the capacity to communicate with Member in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf blind.

I. Pharmacy agrees to participate in a Pharmacy satisfaction survey, approved by DHHS and administered by a third party, should Pharmacy be identified as a participant for said survey.

J. Pharmacy agrees to cooperate fully with client's Quality Assessment and Performance Improvement ("QAPI") Program, as developed and approved by DHHS.

K. Pharmacy agrees to indemnify and hold harmless Network and client should any damages or liquidated damages be paid by either entity as a result of Pharmacy's non-compliance or failure to satisfy any applicable federal or state law.

L. Pharmacy will not release and make public statements or press releases concerning the BMCHP Medicaid Care Management Program without the prior consent of BMCHP and DHHS.

M. Pharmacy also agrees to respond to a BMCHP disability survey, should it be asked to do so, that is developed by the State of New Hampshire, the attestation of which shall be kept on file by BMCHP and shall be available for inspection by the DHHS.

N. Pharmacy agrees to abide by the BMCHP's written Fraud and Abuse policies and initiatives made available to Pharmacy, and if found to be not compliant with policies and initiatives, shall implement corrective actions as agreed to between the parties. Pharmacy shall further cooperate fully with any federal or state agency conducting Fraud and Abuse investigations concerning Member. Full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing

prompt direct access to information, free copies of documents and other available information related to Fraud and Abuse or other violations of government-sponsored health care programs. Pharmacy shall maintain the confidentiality of any such investigation.

NEW JERSEY - COMMERCIAL LINE OF BUSINESS

The following provisions shall govern the contractual relationship between EnvisionRx and participating Pharmacies in the State of New Jersey:

A. Non-Clinical Claims Determination. If a participating Pharmacy disagrees with EnvisionRx non-clinical Claim determination for a commercial Claim payable by a fully-insured entity, the participating Pharmacy may initiate an appeal by submitting to EnvisionRx the New Jersey Department of Banking and Insurance "Health Care Provider Application to Appeal a Claims Determination Form" within ninety (90) calendar days following receipt of notice of the applicable Claims determination.

   EnvisionRx will review the filed appeal and notify the participating Pharmacy within thirty (30) calendar days of the result of the appeal. If the participating Pharmacy disagrees with the appeals determination made by EnvisionRx, the Pharmacy may be eligible to submit the dispute to the New Jersey Program for Independent Claims Payment Arbitration (Arbitration). Information regarding Arbitration, including criteria for dispute eligibility, is available online at: https://njpicpa.maximus.com/. Please note: in order to be eligible for arbitration, the participating Pharmacy must submit its dispute within ninety (90) calendar days of the appeal determination.

B. Recoupment of Overpayments. With the exception of Claims that were submitted fraudulently or submitted by a participating Pharmacy that has a pattern of inappropriate billing or Claims that were subject to coordination of benefits, EnvisionRx will not seek reimbursement for overpayment of a Claim previously paid later than eighteen (18) months after the date the first payment on the Claim was made. EnvisionRx will not seek recoupment of overpayments on or before the 45th calendar day following the submission of the request to the participating Pharmacy for reimbursement on an overpaid Claim. In the event that a participating Pharmacy does not refund the overpayment, EnvisionRx may exercise its right to withhold the requested overpayment amount from the next payment due the participating Pharmacy.

C. Complaints Not Involving Claims Payment or Compensation. If a Pharmacy has a dispute or complaint that does not relate to compensation matters or Claim determination matters, the Pharmacy may contact the EnvisionRx Provider Relations Department. The Provider Relations Department will address complaints within (30) business days from receipt of the complaint. If the Pharmacy is dissatisfied with the resolution reached through the Provider Relations Department, the Pharmacy may submit a verbal or written request directly to the Department of Banking and Insurance via phone call, fax or online complaint form (www.state.nj.us/dobi/consumer.htm#insurance).

D. Termination of Participating Pharmacy. EnvisionRx may terminate its Agreement with a participating Pharmacy at any time by providing ninety (90) days prior written notice to the participating Pharmacy. The termination notice will set forth the Pharmacy's right to obtain a reason for the termination and its right to request a hearing concerning the company's decision to terminate the Pharmacy from the EnvisionRx

Network. To obtain a hearing, the terminated Pharmacy must submit a written request for a hearing within ten (10) business days following the receipt of the termination notice. Please note that the foregoing right to a hearing does not apply if the termination occurs due to: (1) the non-renewal of the Participating Provider Agreement, (2) a determination of fraud, (3) breach of contract by the Pharmacy, or (4) a determination by the company that the Pharmacy poses an imminent danger to Member or to public health, safety and welfare. EnvisionRx will hold a hearing within thirty (30) days following receipt of a written request for a hearing by a terminated Pharmacy before a panel appointed by EnvisionRx. Such hearing will meet the requirements set forth in N.J.A.C. 11:24A-4.9.

WISCONSIN - MEDICAID LINE OF BUSINESS

To be reimbursed for services provided to Member enrolled in Wisconsin Medicaid, BadgerCare Plus, or SeniorCare, Pharmacy is required to be enrolled in Wisconsin Medicaid.

Pharmacy acknowledges that the following requirements have been satisfied:

1. Pharmacy is medical assistance (MA) certified in accordance with DHS 105.01(3)
2. Pharmacy meets the requirements for registration and practice under ch. 450, Stats., and chs. Phar 1 to 17

TEXAS - NETWORK ADMINISTRATION TECHNOLOGY FEE (NATF)

For all applicable lines of business, EnvisionRx will not bill a NATF in compliance with Texas state law.

ACRONYMS

ANDA	Abbreviated New Drug Application
AWP	Average Wholesale Price
BLA	Biologics License Application
CFR	Code of Federal Regulations
CMS	The Center for Medicare and Medicaid Services
COB	Coordination of Benefits
DAW	Dispense as Written
DDPS	Drug Data Processing System
DEA	Drug Enforcement Administration
DUR	Drug Utilization Review
FDA	Food and Drug Administration
FWA	Fraud, Waste and Abuse
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
IC	Ingredient Cost
LEP	Limited English Proficiency
LTC	Long Term Care
MAC	Maximum Allowable Cost
NCPDP	National Council for Prescription Drug Programs
NDA	New Drug Application
NDC	National Drug Code
NPI	National Provider Identifier
NSDE	NDC Structured Product Labeling Data Element
OIG	Office of Inspector General
OPA	Other Payer Amount
OPPRA	Other Payer-Patient Responsibility Amount
OTC	Over-the-Counter
PBM	Pharmacy Benefit Manager
PDEs	Prescription Drug Events
POS	Point Of Sale
PPA	Participating Provider Agreement
PRA	Patient Responsibility Amount
PSAO	Pharmacy Services Administration Organization
TrOOP	True Out Of Pocket
U&C	Usual and Customary
USPS	United States Postal Services