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1. General Information

Caremark appreciates the role that network pharmacies (Providers) play in delivering quality care to our Eligible Persons. The 2020 Caremark Provider Manual ("Provider Manual") contains the policies and procedures to which network pharmacies must adhere in order to provide quality care to Caremark Eligible Persons. The Provider Manual and all Payer Specification Sheets are part of the Provider Agreement and are incorporated into the Provider Agreement pursuant to the terms thereof. This Provider Manual supersedes and replaces all previous versions of the Provider Manual. As a network pharmacy, you are responsible for monitoring and complying with all changes to the Provider Manual. Capitalized terms used in the Provider Manual not defined in the Glossary of Terms shall have the same meaning as in the Provider Agreement.

1.01 Proprietary Statement

The Provider Agreement (which includes the Provider Manual) constitutes Confidential Caremark Information and is provided to Provider for business purposes only. Provider must maintain in confidence the Provider Manual, and must not disclose, sell, assign, transfer or give to any third party the Provider Manual or any of its contents without Caremark’s prior written consent. Refer to section 14.03 Confidentiality of the Provider Manual.

1.02 Requirement to Adhere to Provider Agreement and Pharmacy Manual Requirements

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

1.03 Contacting Caremark

Caremark strives to ensure that Providers receive prompt and courteous assistance with questions that may arise. Caremark’s Pharmacy Help Desk Representatives are available every day of the year. The Interactive Voice Response (IVR) system is available 24 hours a day, 7 days a week, excluding down time for maintenance and service.

1.04 Pharmacy Help Desk

Following are the phone numbers corresponding with the appropriate Bank Identification Numbers (BINs):

<table>
<thead>
<tr>
<th>Caremark System</th>
<th>RXBIN</th>
<th>Pharmacy Help Desk Number*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy ADV</td>
<td>004336**</td>
<td>1-800-364-6331</td>
</tr>
<tr>
<td>Legacy PCS</td>
<td>610415**</td>
<td>1-800-345-5413</td>
</tr>
<tr>
<td>FEP</td>
<td>610239</td>
<td>1-800-345-5413</td>
</tr>
<tr>
<td>Legacy CRK</td>
<td>610029**</td>
<td>1-800-421-2342</td>
</tr>
<tr>
<td>Caremark</td>
<td>610591</td>
<td>As communicated by plan or refer to ID card</td>
</tr>
<tr>
<td>Aetna</td>
<td>610502</td>
<td>1-800-238-6279</td>
</tr>
<tr>
<td>IngenioRx</td>
<td>020099</td>
<td>1-833-296-5037</td>
</tr>
</tbody>
</table>

Secondary RXBINs and Plan sponsor-specific RXBINs and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at:

www.caremark.com/pharminfo

*Or as communicated on Eligible Person’s Card

**Puerto Rico Providers call toll-free 1-800-842-7331

Pharmacy Help Desk representatives will use reasonable efforts to assist providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with respect to the provision of Pharmacy Services. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

Refer to section 10.02 General Information of the Provider Manual for detail on Medicare Part D Calls to the Pharmacy Help Desk.
1.05 Contact Information

Unless otherwise specified in the Provider Manual, Providers must send inquiries and grievances in writing to:

CVS Caremark
Attn: Network Management, MC 080
9501 East Shea Boulevard
Scottsdale, AZ 85260

1.06 Pharmacy Portal

Caremark provides online access to information via its Pharmacy Portal at www.rxservices.cvscaremark.com. Provider may access the Pharmacy Portal to obtain information and other services Caremark may make available. Provider acknowledges that the Pharmacy Portal is an effective medium for communicating Caremark Documents. Provider agrees to check the Pharmacy Portal for updates to ensure awareness of Caremark requirements.

Independent or affiliated-independent providers will be prompted to set a unique username and password as part of the initial login process. Detailed provider-specific account information must be entered as part of the initial login process, including but not limited to, pharmacy NCPDP number (seven digits), pharmacy NPI, state license number, DEA number, etc.

Pharmacy chain and Pharmacy Services Administration Organization (“PSAO”) headquarters who have not received login information from Caremark can contact Caremark for assistance through Provider’s regular contact.

1.06.01 Pharmacy Portal Terms of Use and Confidentiality Statement

Only pharmacy entities contracted with Caremark as a network provider (and their authorized representatives) may access the Pharmacy Portal, consistent with the Provider Agreement. A user account may only be utilized by the pharmacy Caremark approves as part of the user account registration process. By logging onto the Pharmacy Portal, the user represents it has received approval from Caremark to access the Pharmacy Portal and reimbursement data. Additionally, the user agrees to only access the user account for which it has been approved. Users must not access an account belonging to another user.

The Pharmacy Portal may provide authorized users with various analytical tools (such as MAC Price Lookup, MAC Appeals, MAC Future Pricing, etc.). The Pharmacy Portal, and its content, are the property of Caremark and users are strictly prohibited from using Pharmacy Portal content or information for any purpose other than for the purposes of fulfilling the provider’s obligations under the Provider Agreement. Users are strictly prohibited from accessing the Pharmacy Portal using automated means (such as harvesting bots, robots, spiders or scrapers). Caremark reserves the right to remove content from the Pharmacy Portal at its sole and absolute discretion. Improper use or unauthorized access of the Pharmacy Portal may result in termination of Pharmacy Portal use privileges and pursuit of all other remedies available to Caremark.

The information provided in the Pharmacy Portal is Caremark’s confidential and proprietary information and considered “Confidential Caremark Information” as this term is defined in the Caremark Provider Manual. Pursuant to the terms of the Caremark Provider Manual, you may not disclose, sell, assign, transfer, or give the information contained therein to any third party.
1.07 Top Questions Asked by Providers

1. What date of birth, sex and/or person code do you have on file for this Eligible Person?

Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable attempts/efforts to obtain the necessary information for claim submission. In the event a Plan Sponsor has incorrect eligibility information (e.g., incorrect date of birth), when a Provider submits a claim using the correct eligibility information (e.g., correct date of birth) the claim will reject. In most cases, Caremark will be able to assist the Provider at the point of service with any discrepancies with eligibility information, such as date of birth and sex. However, you should advise your patient that he or she should inform his or her Plan Sponsor of the incorrect eligibility information and that until it is corrected claims will continue to reject.

2. What is the identification number for this Eligible Person?

Provider must request to see the identification card for the Eligible Person to ensure that the prescription is written by the Prescriber for an Eligible Person.

3. Are person code and patient relationship code required for claim submission?

Person code (as printed on the identification card) and patient relationship code data fields are required for submission as outlined in the Caremark Payer Sheets. Many times, person code is printed on the identification card. It is important that this information is submitted accurately to Caremark in order for appropriate Drug Utilization Review (DUR) for that individual to occur.

4. What Banking Identification Number (RXBIN) do I use for all Caremark Eligible Persons?

Provider should submit claims utilizing the corresponding RXBIN which, in most cases, is illustrated on the identification card. A complete list of RXBINs is located on the previous page.

5. Is a Processor Control Number (RXPCN) required for claim submission?

Provider must request to see the identification card for the Eligible Person and examine the identification card to determine if RXPCN information is available. Submit the RXPCN information as it appears on the identification card. If no RXPCN appears on the identification card, submit the default RXPCN according to the RXBIN as outlined in the Caremark Payer Sheets found online at www.caremark.com/pharminfo.

6. What is the Group (RXGRP) number for this Eligible Person?

The RXGRP number is located on the Eligible Person’s identification card. Refer to section 3.01.03 Identification Cards of the Provider Manual.

7. What is the amount this Eligible Person must pay?

Provider must submit the claim through the claims system to receive the adjudicated response which will include the amount to collect from the Eligible Person as well as information about eligibility, plan coverage, pricing and applicable clinical programs and services. The representatives at the Pharmacy Help Desk cannot release information about the amount the Eligible Person must pay due to the variables that may impact cost-share.

8. Is this Eligible Person eligible to receive a vacation supply?

Many Plan Sponsors allow for Eligible Persons to secure an early refill for vacation supply. If the Eligible Person states that he or she is eligible for an early refill for vacation supply, Provider must submit the claim as usual. If the claim rejects, Provider should contact the appropriate Pharmacy Help Desk for coverage verification. If the Plan Sponsor does allow for an early refill for vacation supply, the representative from the Pharmacy Help Desk will enter an override.

9. What is the prior authorization procedure for this Eligible Person?

Caremark only administers Prior Authorization programs for some of its Plan Sponsors. Therefore, Provider should note the adjudication response which generally includes the online retransmission instruction or appropriate contact information and telephone numbers.

10. What are the plan limits for this Eligible Person?

Provider must submit the claim through the claims adjudication system to receive the adjudicated response which will include messaging about plan coverage. The representatives at the Pharmacy Help Desk cannot release plan limitation information due to the variables that may impact the coverage for a given drug.
11. May I waive patient copays?
   Provider must follow the requirements of the Provider Agreement (including the Provider Manual) for collection of Patient Pay Amounts. Refer to section 3.03 Patient Pay of the Provider Manual.

12. How do I know if the Plan allows Coordination of Benefits?
   Plans may indicate if an Eligible Person’s eligibility is supplemental, and Provider may receive a reject indicating that the claim should be submitted to another payer or other COB related message. For Plan Sponsors that allow Coordination of Benefits (COB), refer to section 4.10 Coordination of Benefits of the Provider Manual for additional information regarding COB claim submission.

13. Do I need to bill the specific National Drug Code dispensed?
   Yes. Submitted claims information must be accurate and complete. This includes, but is not limited to, billing the actual National Drug Code (NDC) used for each item within a prescription for compound recipe.

14. What data field do I use for the <specific data>?
   Representatives from the Pharmacy Help Desk will reasonably assist Provider where possible to determine which data field should be used for specific data. However, due to the numerous types of software, it is difficult for the representatives to know how each system is set up. Providers should consult with their software vendor or chain headquarters for technical assistance.

15. I am a new provider owner. Am I responsible for the liabilities and obligations of the previous owner?
   Yes. Refer to section 2.07 Change in Ownership of the Provider Manual.

16. What information is on the Caremark Pharmacy Portal and how do I obtain access?
   In addition to downloading the Caremark Provider Manual, Providers can also download Provider Manual Amendments, Medicare Part D Plan Sponsor Information, and Vaccine Administration Networks Plan Information from the Pharmacy Portal. Providers can look up Maximum Allowable Cost (MAC) Price using the online mock adjudication and may also submit MAC paid claim appeals via the Pharmacy Portal. Refer to sections 1.06 Pharmacy Portal and 6.04 Maximum Allowable Cost of the Provider Manual.

For additional claim processing information, refer to the Caremark Payer Sheets at:

www.caremark.com/pharinfo.

Note: This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Caremark.
2. Credentialing and Quality Management

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

In order to become a Provider and prior to being allowed to submit claims for payment to Caremark, a pharmacy must accurately complete and submit an application and other documentation required by Caremark, meet Caremark’s credentialing requirements, and be able to comply with the requirements of the Provider Agreement, including this Provider Manual. Provider’s agreement with Caremark does not guarantee participation in all networks. Caremark, on its own behalf in its sole discretion, or on behalf of a Plan Sponsor, may limit Provider’s participation to certain networks. For any Provider with multiple locations, Caremark retains the right to limit participation to one or any number of Provider’s pharmacy locations.

Provider must comply with all of Caremark’s standards and requirements, credentialing, and quality management initiatives in order to participate in Caremark’s network(s), including but not limited to, all applicable federal, state, and local laws as described more fully below.

Caremark has the right to determine, in its sole discretion, whether a provider meets Caremark’s credentialing and quality management standards to serve as a Provider for Caremark and its Plan Sponsors. Caremark’s determination may include, but is not limited to:

- Denial of enrollment, or
- The right to terminate the Provider Agreement

In making this determination, Caremark may look at all available evidence and may deny enrollment or terminate the Provider Agreement in its sole discretion, including but not limited to, based on:

1. Any noncompliance with the terms of the Provider Agreement, serious and/or significant audit findings, or adverse actions by a governmental regulatory or enforcement entity or agency against:
   a. Provider;
   b. Another provider with any common association, ownership or relationship to Provider; or
   c. Any of Provider’s respective owners (direct or indirect), officers, directors, employees or affiliated personnel. This also includes Providers that have billed for other entities or that have billed for claims that were previously found to have migrated from other Providers removed from the network.
2. Any conduct that may adversely impact Caremark’s relationship with, or Caremark’s contractual duties to, a Plan Sponsor;
3. Any conduct that may pose a risk to the health, welfare, safety, or financial well-being of Eligible persons or the general public;
4. Any other conduct that Caremark, in its sole discretion, determines would adversely affect Provider’s ability to fulfill the requirements of the Provider Agreement; or
5. If Caremark believes, in its sole discretion, that the Provider may pose an undue risk of potential Fraud, Waste, and/or Abuse.

IMPORTANT:

1. Failure to maintain compliance with any of the credentialing standards set forth below may be used as grounds for termination by Caremark. Caremark also reserves the right to recoup any payments made for claims submitted while Provider is in violation of these standards.
2. Incomplete or inaccurate information provided as part of the application process may result in remedial action by Caremark, including but not limited to, Provider Agreement termination or denial of provider enrollment.
3. Provider shall be responsible for paying the credentialing and recredentialing fee upon the initial application to Caremark and upon full recredentialing, when applicable.

2.01 Steps to Become a Provider

1. Complete the “Pharmacy Pre-Enrollment Questionnaire”
2. Create a Pharmacy Portal account
3. Complete and submit your application, which includes attestation to Provider Agreement
2.01.01 Complete the “Pharmacy Pre-Enrollment Questionnaire”
To become a participating provider in a Caremark or Plan Sponsor Network, Provider must accurately complete and submit the “Pharmacy Pre-Enrollment Questionnaire” in order to initiate the enrollment process. This includes disclosing information as set forth in “Disclosure of Information by Providers and Fiscal Agents” (42 C.F.R. Part 455, Subparts B, E) and “Disclosure of Ownership and Control Information” (42 C.F.R. Part 420, Subpart C).

1. Access the “Pharmacy Pre-Enrollment Questionnaire” at www.caremark.com/pharminfo and select “Pharmacy Pre-Enrollment Questionnaire”.
2. Supply the required information as outlined in the “Pharmacy Pre-Enrollment Questionnaire”. It is important for all Providers to complete the form accurately and in its entirety as Caremark relies on this information in making enrollment determinations.
3. Submit the online questionnaire. Upon successful completion of the “Pharmacy Pre-Enrollment Questionnaire” and approval by Caremark, instructions for creating an online Pharmacy Portal account will be sent to the applicant.

Caremark may require additional pre-enrollment credentialing in its sole discretion. This can include, but is not limited to, pharmacies located in established Health and Human Services-Office of Inspector General (HHS-OIG) designated Health Care Fraud Prevention and Enforcement Action Team (HEAT) areas.

2.01.02 Create a Pharmacy Portal Account to Submit Enrollment Application
Provider must create an online account using the Pharmacy Portal in order to complete and submit an online enrollment application. The online enrollment application must be accompanied by an electronic submission of all required documentation required therein. Failure to submit the online enrollment application within thirty (30) days from the date it was initiated will result in the expiration of the enrollment application thus warranting the applicant to restart the enrollment application process.

At the time of enrollment application submission, the enrollment fee is due and payable.

1. Caremark charges a $1,200 non-refundable fee for each application of enrollment, a $2,000 non-refundable fee for pharmacies located in or near designated HEAT areas, and a $1,500 non-refundable fee for Dispensing Practitioners, regardless of whether Caremark enrolls the Provider. Fees are due at the time of application submission.
2. Caremark charges a $75 fee per pharmacy location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application.
3. Payment must be submitted to Caremark in the form of a cashier’s check, made payable to “CVS Health” and mailed to the address below. Failure to submit payment or provide all required enrollment information and documentation within thirty (30) days will result in the denial of the enrollment application. Review of enrollment application will not proceed until payment is received.

Mail cashier’s checks to:
CVS Health
Attn: Provider Enrollment, MC 129
9501 E. Shea Blvd.
Scottsdale, AZ 85260

4. Submit enrollment questions to Caremark via the “enrollment self-service/pharmacy provider question form” found at caremark.com/pharmacy.

2.01.03 Complete and Submit Your Application
Once the applicant submits the online enrollment application, the applicant will be notified via email by Caremark if any required documentation or information is missing or incomplete. The review of an application will not begin until a complete application is received; the enrollment application is not deemed to be complete until all pieces of required documentation, including but not limited to, the attestation to the Provider Agreement, are submitted to Caremark. Enrollment applications are reviewed in the order in which they were received. Enrollment decisions are communicated to applicants via email.

2.02 Steps to Become a Complex Compound Provider
In order to become an approved Provider to dispense and submit non-sterile complex compound claims to Caremark, the provider must first be currently enrolled with Caremark (refer to section 2.01 Steps to Become a Provider of the Provider Manual) and accurately complete, in its entirety, the Caremark Compound Application.

Providers wishing to submit a Caremark Compound Application may contact Caremark at
Credentialing and Quality Management

In order to apply as a non-sterile complex compounding pharmacy, the provider must meet the following minimum requirements:

1. The provider must be an established non-sterile complex compound pharmacy able to provide a list of their top ten compounds.
2. The provider must offer a variety of dosage forms.
3. The provider, pharmacy staff (including the pharmacist in-charge), and owner(s) are currently in good standing with Caremark.

Steps to become a non-sterile complex compound provider:

1. Complete the Caremark Compound Application and return with all applicable supporting documents to CompoundApplicationTeam@CVSHealth.com.
2. Caremark charges a $500 application fee. Payment must be submitted to Caremark in the form of a cashier’s check or money order made payable to “CVS Health” and mailed to the address below. This application fee is non-refundable and in no way ensures that the pharmacy will be approved to be in Network and able to submit complex compounds.

Mail cashier’s checks to

CVS Health
ATTN: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

IMPORTANT: Incomplete or inaccurate information provided as part of the Complex Compound Provider application process may result in remedial action by Caremark, including but not limited to, Provider Agreement termination or denial of the provider’s Caremark Compound Application.

2.03 Plan Sponsor Networks

Providers wishing to participate in a Plan Sponsor network may send an email to RxServices@CVSHealth.com and provide the provider’s name, the corresponding National Provider Identifier (NPI) and National Council for Prescription Drug Programs (NCPDP) number, the contact name, the telephone number, and the reason for the email.

2.04 Credentialing Requirements

In order to become and remain a provider contracted with Caremark, a provider must comply with Caremark’s requirements. These obligations are to be fully met during the enrollment review process and continue on post-enrollment for the duration of provider’s participation in Caremark networks.

All providers must comply with all applicable laws and regulations and provide all pharmacy services and covered items in a professional manner, and in compliance with the highest industry pharmacy practice standards. Failure to comply may result in remedial action by Caremark, including but not limited to, Provider Agreement termination. These requirements include, but are not limited to the following:

1. Provider must maintain in good standing all federal, state, and local licenses, permits and certifications as required by law.
2. Provider must maintain at all times current and valid pharmacy licensure as issued by the appropriate state agency in which the provider operates to dispense medications or into which it ships medications. Additionally, the provider must meet all standards of operation as described in federal, state, and local laws. Any pharmacy services provided where the provider does not possess all required active and valid licenses and/or permits under applicable law shall be deemed to be invalid and subject to chargeback.
3. All pharmacy services must be provided by or under the direct supervision of a licensed pharmacist and in accordance with prescriber directions and applicable law.
4. Provider must require and verify that all personnel employed by or contracted with the provider are licensed and qualified to perform their professional duties and that they act within the scope of their licensure.
5. Notwithstanding anything in the Agreement to the contrary, the provider must comply with all applicable federal, state, and local laws (including any local laws and regulations) in performing its pharmacy services under the Agreement.
Agreement, including but not limited to, the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395nn); and Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Parts 160, 162, and 164, and the Controlled Substance Act (21 U.S.C. 801-971).

6. Provider must require and verify that Provider and all personnel employed by or contracted with Provider have not been excluded or debarred by any federal or state program. Provider must check the applicable state and federal exclusion lists on a monthly basis to verify that no employees or contractors are on the list. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

7. Provider must require and verify that any individual for whom there has been a restriction, suspension revocation, probation or any other disciplinary action taken does not provide any service to Caremark or its Eligible Persons. Provider agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

8. Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions prescribed or claims for items or services furnished by an excluded or debarred Prescriber, and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

9. Provider must maintain, at its cost and expense, policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1,000,000 per person and $3,000,000 in aggregate, unless otherwise agreed to by Caremark, or such greater amount as required by Law.
   a. Provider must furnish copies of said policies upon enrolling as a Provider with Caremark and as requested by Caremark thereafter. Failure to maintain the minimum coverage may result in immediate termination.
   b. Provider must notify Caremark immediately in writing if its insurance is canceled, lapsed or otherwise terminated. Failure to notify Caremark in writing of any such termination of insurance coverage may result in immediate termination.
   c. Provider must notify Caremark of any changes to the policy, including but not limited to, the location schedule.

10. Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

11. Provider must support all clinical programs and services and utilize software that will display all messages related to clinical programs and services and that provide for the recording of patient drug and medical information, where utilized by Caremark and as allowed by applicable Law.

12. Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.

13. Provider must dispense prescriptions using standards of operation approved by Caremark and defined in section 4. Claims Submission of the Provider Manual. Delivering to Eligible Persons by mail or other common carrier as a routine business practice in excess of the percentage allowed by Caremark is unapproved without the express written permission of Caremark. Payment for claims involving unauthorized mail or other remote delivery carrier are subject to chargeback.

14. Providers who utilize an internet site as a routine business practice in the provision of Pharmacy Services (except for refill requests) must maintain Verified Internet Pharmacy Practice Sites (VIPPS) certification through the National Association of Boards of Pharmacy (NABP), but must also otherwise comply with the terms of this subsection.

2.05 Re-Credentialing

Caremark will periodically re-credential Providers. When requested, Provider will be required to submit requested information to Caremark. Failure to supply the documentation in the requested manner and time period may result in suspension, probation, or termination. Caremark reserves the right to increase the transaction fee to a minimum fee of $0.99 per transaction transmitted for failure to provide the requested re-credentialing documentation until such time as the request is complete.
2.06 Notification to Caremark

2.06.01 Notification of Change in Documentation and Other Information

Unless otherwise specified, Provider must notify Caremark in writing within ten (10) business days of any change in the Provider credentials, documentation and other information provided to Caremark in connection with enrolling as a Provider, including but not limited to, change in credentialing information (e.g., change in “Pharmacy Pre-Enrollment Questionnaire” information, change in enrollment application), name, contact information, services, hours of operation, or 24-hour status.

Notwithstanding the foregoing, Provider must notify Caremark of a change in the Provider’s physical location prior to the change. Provider is liable to Caremark for any losses that Caremark incurs (e.g., penalties to a Plan Sponsor) based on Provider’s failure to comply with this sub-section. Provider must be reasonably reachable by telephone or facsimile during Provider’s hours of operation based on the contact information provided (and as updated) to Caremark as part of enrollment, credentialing or re-credentialing.

Provider must send such notification to Caremark using one of the following options:

- Fax to 480-661-3054
- Mail to:
  CVS Caremark
  Attn: Provider Enrollment, MC 129
  9501 E. Shea Boulevard
  Scottsdale, AZ 85260

- Submit an online “Pharmacy Change Form” located on Caremark.com/For Pharmacists and Medical Professionals/Pharmacy Enrollment Self-service/Pharmacy Change Form

2.06.02 Notification of Closure

Provider must notify Caremark in writing of pharmacy closure by no later than ten (10) business days after a closure of its business. Contained within this notification must be the name of the records custodian in the event of future audit-related requests for documentation and information from Caremark or a governmental agency.

Mail to:

CVS Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

2.07 Change in Ownership

A change in ownership or control is defined as (1) any change in who holds, directly or indirectly, the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (2) the right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party.

Provider must notify Caremark of a change in ownership or control, as defined above, in writing within ten (10) business days of the change. Changes in pharmacy provider ownership are subject to Caremark’s standard pre-enrollment credentialing review process and fee assessment (refer to section 2.01 Steps to Become a Provider of the Provider Manual). In order to initiate the change in ownership enrollment process, Provider may submit a “Pharmacy Pre-Enrollment Questionnaire” found at www.caremark.com/pharminfo and select “Pharmacy Pre-Enrollment Questionnaire”, wherein the enroll type of “change of ownership” is selected. Upon successful submission of the Pharmacy Pre-Enrollment Questionnaire, instructions for the creation of an online pharmacy portal account will be sent to applicant via email.

Caremark reserves the right to terminate any Provider Agreement for failure to notify Caremark of a change in ownership or control. To the extent the change of ownership or control interrupts or impacts the terms of existing contracts with Caremark, Caremark reserves the right to cancel such obligations and have no further responsibility or liability for those obligations.

1. Where the Buyer (defined as any successor in interest to an owner or operator) has no existing relationship with Caremark:
a. It must execute a new Provider Agreement and meet all of Caremark’s credentialing requirements, including completion of the Pharmacy Pre-Enrollment Questionnaire in order to initiate the credentialing process for the acquired pharmacy or pharmacies.

b. Caremark, in its sole discretion may allow assignment of the Provider Agreement for the acquired pharmacy to the Buyer.

2. In the event that the Buyer has an ownership interest or operating rights in an existing Provider, Caremark may elect to:
   a. Apply in whole or in part the terms of the acquired pharmacy's Provider Agreement to the acquired pharmacy or pharmacies;
   b. Apply in whole or in part the terms of the Buyer's Provider Agreement to the acquired pharmacy or pharmacies; or
   c. Require Buyer to complete credentialing and execute a new Provider Agreement for the acquired pharmacies.

The Buyer agrees to assume responsibility for and to guarantee any acquired pharmacy’s performance of its obligations under any Caremark Provider Agreement, including any financial obligations, obligations to comply with applicable Law, and the obligation to cooperate with Caremark’s audit requirements, whether such obligations arose before or after Buyer’s acquisition of an ownership interest in or operating rights with respect to such acquired pharmacy.

Provider shall inform Caremark in writing within ten (10) business days of the sale of any prescription files.

Mail to:
CVS Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

Failure to submit any required documentation related to above within the required timeframe may result in Provider termination. All Change in Ownership notifications are subject to Caremark review, and are not a guarantee of Provider enrollment.

2.08 Requests for Documentation
Caremark may request copies of all documents required for credentialing at any time. Appropriate documents must be provided to Caremark within ten (10) business days.

Provider must respond to Caremark within ten (10) business days of a request for documentation necessary to support claims processing or audits by Plan (or of Plan).

Caremark charges a $75 fee per Provider location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application, and such fee may be offset against other amounts owed to Provider.

2.09 Reporting of Investigations and Disciplinary Actions
Provider must notify Caremark in writing within ten (10) business days with detail if:

1. Any of Provider’s licenses or permits that are required under applicable Law for Provider to provide Pharmacy Services is, or is in jeopardy of being, suspended or revoked;

2. There are proceedings related to Pharmacy Services that may lead to an adverse action against Provider or affiliate of Provider, or any of their respective officers, directors, current/former employees, or owners (direct or indirect);

3. Any adverse action is taken against (a) Provider; (b) officer, director, current/former employee, owner (direct and indirect) of Provider or affiliate of Provider, including but not limited to, action taken by a Board of Pharmacy, Officer of Inspector General (OIG), System for Award Management (SAM), law enforcement, Drug Enforcement Agency (DEA), or other regulatory body;

4. There is a subpoena of records, issuance of a civil investigative demand letter, plea of no contest, or a filing of a civil lawsuit against a Provider related to Pharmacy Services or Provider’s business practices;

5. There is a seizure by law enforcement of Provider’s prescription records, computer systems, financial records, accounts, or real property;
6. Provider or affiliate of Provider, or any of their respective officers, directors, employees, or owners (direct and indirect) enters into a settlement agreement, Corporate Integrity Agreement, or consent order with a governmental or regulatory agency relating to Pharmacy Services or Provider’s business practices, even if there is no admission of liability; or

7. Provider is terminated from a third-party payer’s (including a pharmacy benefit manager) network based on cause.

Provider must notify Caremark in writing to:

CVS Caremark
Attn: Provider Enrollment, MC 129
9501 East Shea Boulevard
Scottsdale, AZ 85260

Failure to timely and properly notify Caremark may result in termination of the Provider Agreement or suspension as a participating Provider.

In the event that Caremark receives notice of any of the above investigations and/or disciplinary actions described in this section, Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider in its sole discretion or if required by applicable Law.

2.10 Criminal Offense Related to Federal Health Care Programs

2.10.01 Pharmacy Criminal Offense
Provider must notify Caremark in writing within ten (10) business days if Provider or any of its officers, directors, employees, contractors, agents, or volunteers who provide items or services that will be paid by Medicare, Medicaid, or other Federal or federally-funded health care program or any of its owners has been, within the ambit of 42 U.S.C. § 1320a-7(a) or 1320a-7(b)(1)-(3):

1. Charged with or convicted of any criminal offense (a) related to the delivery of an item or service under any Federal or federally-funded health care program (including Medicare or Medicaid); (b) related to the neglect or abuse of a patient in connection with the delivery of a health care item or service; (c) which is a felony and related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct; (d) which is a felony and related to the unlawful manufacture, distribution, prescription, or dispensing of a Covered Item; or

2. Proposed for exclusion or debarment from participation in Medicare, Medicaid, or other Federal or federally-funded health care program.

For purposes of Provider’s notification hereunder, the term “convicted” includes (1) when there has been a finding of guilt against Provider or Provider’s officer, director, employee, contractor, agent, volunteer or owner; (2) when Provider or Provider’s officer, director, employee, contractor, agent, volunteer or owner has entered and a court has accepted a plea of guilty or nolo contendere (no contest); (3) when Provider or Provider’s officer, director, employee, contractor, agent, volunteer or owner has entered into a pre-trial agreement to avoid conviction; and (4) when Provider or Provider’s officer, director, employee, contractor, agent, volunteer or owner has entered into participation in a First Offender, deferred adjudication, pardon program, or other arrangement or program where a judgment of conviction has been withheld.

2.10.02 Prescriber Criminal Offense
Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber whom Provider knows has been convicted of any criminal offense as described above within the ambit of 42 U.S.C. § 1320a-7(a). Provider must notify Caremark in writing within ten (10) business days if Provider has knowledge or information of a Prescriber who has been charged with or convicted of any criminal offense as described above within the ambit of 42 U.S.C. § 1320a-7(a). Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

2.11 Federal Health Care Programs Participation Exclusion: Pharmacy

If Provider is excluded or debarred from participation in any Federal health care program (as defined in 42 U.S.C. 1320a-7b(f)), Provider must immediately notify Caremark of any such exclusion or debarment. Provider will be immediately terminated from participation in all Caremark networks. Provider shall not submit any claim to Caremark for a prescription dispensed by Provider if Provider is excluded or debarred from participation in any Federal health care program.
Provider shall not allow any person (whether as an officer, director, employee, contractor, agent, volunteer, owner or otherwise) who is excluded or debarred from participation in any Federal health care programs to directly or indirectly provide any item or service under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services. Provider agrees to implement a policy requiring all new and existing persons engaged by Provider (whether as an officer, director, employee, contractor, agent, volunteer, owner or otherwise) to immediately disclose to Provider any debarment, exclusion, or other event that makes them ineligible to perform work related directly or indirectly to Federal health care programs. Upon such disclosure, Provider must immediately reassign such person to work that does not involve or relate, directly or indirectly, to the provision of items or services under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services.

Provider hereby certifies that:

1. Provider will review the OIG List of Excluded Individuals/Entities (LEIE) and SAM list upon initially hiring or engaging any officer, director, employee, contractor, agent, volunteer, owner, or otherwise, and monthly thereafter and upon any change of ownership in order to ensure that Provider does not allow any person who is excluded or debarred from participation in any Federal health care program to directly or indirectly provide any item or service under the Agreement or otherwise in connection with the Pharmacy Services, including without limitation, any administrative or management services. Provider agrees to provide such additional information or documentation in this regard as Caremark may reasonably require.

2. Provider will review the Social Security Administration’s Death Master File upon initially hiring or engaging any officer, director, employee, contractor, agent, volunteer, owner or otherwise, and monthly thereafter and upon any change of ownership in order to prevent fraudulent use of social security numbers.

Provider agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to chargeback.

Notwithstanding anything to the contrary, if an exclusion is made by an individual state health care program or other government sponsored program, but the exclusion does not extend to all Federal health care programs, Caremark may, in its sole discretion, limit the scope of termination to termination from only certain Caremark networks.

If Provider is excluded or debarred from participation in any Federal health care program:

- Provider will promptly provide to Caremark upon request a list, in such detail as Caremark requires, of all Federal health care program claims submitted on or after the date of such exclusion. All such identified claims are subject to reversal by Caremark as required by Law, Plan Sponsor, or as otherwise deemed necessary or appropriate by Caremark.

If any of Provider’s officers, directors, employees, contractors, agents, volunteers or owners are excluded or debarred from participation in any Federal health care program:

- Provider will promptly provide to Caremark upon request a list, in such detail as Caremark requires, of all Federal health care program claims for which the excluded person directly or indirectly provided Pharmacy Services or on or after the date of such exclusion. All such identified claims are subject to reversal by Caremark as required by Law, Plan Sponsor, or as otherwise deemed necessary or appropriate by Caremark.

2.12 Diverse Retail Pharmacy Program

The Caremark Supplier Diversity Program targets diverse suppliers of products and services for Caremark’s use. The program is designed to complement Caremark’s commitment to providing outstanding service to its customers, and it recognizes the critical role diverse suppliers have in its continued success. The Supplier Diversity Program is founded on the principles of sound business practices and social responsibility to the community in which Caremark serves.

One component of the Supplier Diversity Program is the Diverse Retail Pharmacy Program. Under this program Caremark encourages diverse-owned, independent retail pharmacies to become certified business enterprises in order to expand and establish potential business opportunities, sustain and grow their business, take advantage of possible governmental programs, and expand and establish potential new opportunities with other business entities.

Any diverse-owned and operated retail pharmacy contracted with Caremark and certified as a diverse business enterprise by a government or third-party entity can apply for participation in the Diverse Retail Pharmacy Program. Just complete and submit the Caremark Supplier Diversity Profile Form. For more information on this program and the Caremark Supplier Diversity Profile Form, refer to Appendix E of the Provider Manual.
3. Pharmacy Services and Standards

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Pharmacies are an important part of Caremark’s services and our goal to help people on their path to better health. Our Plan Sponsors, which include insurance companies, managed care organizations, third-party administrators, federal and state entities, employers, and union-sponsored benefit plans, entrust us with serving their diverse membership and we are committed to providing them with innovative and quality services and measures to control healthcare spending and improve health outcomes. Through our health services, plans and community pharmacists, we are pioneering a bold new approach to total health, making quality care more affordable, accessible, simple and seamless, to not only help people get well, but help them stay well in body, mind and spirit.

3.01 Providing Pharmacy Services to Eligible Persons

3.01.01 Professional Judgment and Conduct
All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist and in accordance with Prescriber directions and applicable Law. Provider must at all times exercise professional judgment in providing Pharmacy Services to an Eligible Person. Provider may refuse to provide Pharmacy Services to an Eligible Person based on professional judgment.

3.01.02 Verification of Eligible Persons
Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Eligible Persons must present an Identification Card to Provider when having a prescription filled. Provider must utilize the information on the Eligible Person’s identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable efforts to obtain the necessary information for claim submission. Provider will not be reimbursed for providing Pharmacy Services to an Eligible Person whose eligibility was incorrectly submitted.

3.01.03 Identification Cards
In most cases, the identification card will be produced in the most current NCPDP format and will contain the Eligible Person’s identification number, the RXBIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information.

An identification card may show coverage for the Eligible Person only or it may show coverage for the Eligible Person and his or her dependents.

3.01.04 Nondiscrimination
Provider must not discriminate against an Eligible Person on the basis of race, color, national origin, gender, age, religion, disability, medical condition, political convictions, sexual orientation, Eligible Person’s enrollment in a Plan, source of payment, marital or family status, or any other basis prohibited by Law. Unless professional judgment dictates otherwise, Provider must deliver Pharmacy Services related to Covered Items to all Eligible Persons.

3.01.05 Eligible Person Solicitation
Provider must not directly or indirectly obtain prescriptions for Eligible Persons via marketing activities, including but not limited to, (1) contacting Eligible Person or Prescriber without a previously existing relationship; (2) obtaining an Eligible Person’s primary care provider or billing information through unsolicited methods; and/or (3) contacting or offering to contact a Prescriber on an Eligible Person’s behalf without the Eligible Person’s express knowledge and authorization for each specific claim. Provider shall not obtain a prescription from a Prescriber not expressly requested by the Eligible Person or by suggesting to an Eligible Person that his or her Prescriber or health plan wants the Eligible Person to receive the medication without the prescriber’s express knowledge and authorization. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives, including but not limited to, adherence initiatives, gaps-in-care management, or comprehensive medication reviews with Eligible Persons.
3.01.06 Eligible Person Complaints
Provider must cooperate with Caremark and Plan Sponsors to resolve Eligible Person complaints. Provider must make a reasonable effort to rectify the situation that leads to the Eligible Person complaint. Provider must maintain written records of events and actions surrounding each complaint.
Provider must participate in and comply with a Plan’s applicable appeal, grievance, and external review procedures, including Medicare Part D appeals and expedited appeals procedures, and the resulting decisions of the Plan.
Provider must provide to Caremark timely responses for CMS Complaint Tracking Module (CTM), in accordance with CMS-specified response times, which are typically within 24 hours of receipt of the grievance.

3.01.07 Patient Receipts and Insurance Profiles
Provider may print U&C and Patient Pay Amount on receipts and insurance profiles provided to an Eligible Person. Provider reimbursement pricing information and prices paid to Provider for individual claims under this Provider Agreement are Confidential Caremark Information and may not be disclosed on patient receipts or insurance profiles, subject to applicable Law. Refer to section 14.03 Confidentiality of the Provider Manual.
Caremark has the right to review and audit documentation to validate Provider’s compliance with this section.

3.01.08 Educational Materials and Efforts
Provider must utilize all educational materials to benefit Eligible Persons. All information contained in educational materials related to products, programs, services, and Plan Sponsor announcements constitute Caremark Documents and are Confidential Caremark Information.
Caremark may educate Provider about products, programs and services as well as distribute Plan Sponsor announcements. Educational materials may be distributed through various means, including e-mail, facsimile, mail, or posted on one of the Caremark websites or the Caremark Pharmacy Portal. Refer to section 1.06 Pharmacy Portal of the Provider Manual.

3.02 Dispensing Requirements
3.02.01 Hours of Operation
Provider must maintain hours of operation that meet the needs of the community, but in all circumstances in accordance with applicable Law. Provider must communicate those hours of operation to Caremark upon enrollment and upon any changes. Provider must be reasonably reachable by telephone or facsimile during Provider’s hours of operation (except as described in the “Force Majeure” section of this agreement). In the event that Provider is unreachable after reasonable attempts, Caremark reserves the right to suspend the participation status and other remedies available to Caremark, pending further investigation.

3.02.02 Drug Stock and Inventory
Provider must stock a sufficient amount of drugs, at Caremark’s reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

3.02.03 Aberrant Quantities and Volume
Provider must not dispense aberrant quantities of a Covered Item and/or high volume of claims within a therapeutic category (e.g. topicals, dermatologicals), as measured by number of claims, quantity dispensed or dollars, inconsistent with the habits of local Prescribers or Plan Sponsor formularies, at Caremark’s sole determination. In the event Provider breaches this provision of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark, including chargeback of applicable claims.

3.02.04 Dispensing Covered Items to Eligible Person’s Agent
Provider must obtain the consent of the Eligible Person in order to dispense a Covered Item to a licensed healthcare practitioner in a non-custodial setting, except for deliveries to a family member of the Eligible Person when the Eligible Person is not present at the time of the dispensing of the Covered Item.

3.02.05 Performance Initiatives
Provider must support all Caremark performance initiatives, such as but not limited to, performance network programs (which may include adherence and drug therapy gap alerts), retrospective safety review alerts, formularies, Prior Authorization program, Managed Drug Limitations program, generic incentive programs, Dose Optimization program, Step Therapy program (refer to section 5. Clinical Programs, Services and Related Messages of the Provider Manual for a further description of these initiatives) and any criteria in such performance initiatives.
As part of the performance initiatives, Provider must inform Eligible Persons when a non-formulary drug has been prescribed and Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider may be paid a fee for services related to such performance initiative efforts.

Provider must not participate in programs that increase the amount billed to Plan Sponsors for Covered Items.

3.02.06 Dispensing Errors
If, as a result of an Eligible Person complaint, claim review, or Prescriber verification, for example, Caremark identifies a potential dispensing error and confirms with Provider the occurrence of such dispensing error, Provider must (1) review the information with the Eligible Person, (2) document the error in accordance with Provider’s internal operational procedures, (3) report the error, if required, to any appropriate regulatory agency, including but not limited to, the Institute for Safe Medication Practices (ISMP), and (4) follow all applicable Law. For paid claims that have been determined to have a dispensing error, Caremark reserves the right to charge back the entire claim amount and may request Provider refund the Eligible Person the Patient Pay Amount.

Caremark tracks all dispensing errors identified through Caremark programs and provides notice to Provider of each error. Errors identified are reported internally for clinical review and serious or multiple errors may result in the Provider being notified of a Corrective Action Required (CAR), in which case Provider may be required to provide a Corrective Action Plan (CAP) to detail mechanisms being employed to prevent future errors. Refer to section 8.08 Corrective Action Plan of the Provider Manual.

3.03 Patient Pay

3.03.01 Collection of Patient Pay Amounts
Patient Pay amounts (e.g. Copayments, Coinsurance, etc.) is an extremely important tool to help align the needs of Plan Participants with those of the Plan Sponsor. The disclosure of the Patient Pay Amount to the Patient is an important step in the adjudication and dispensing process of a prescription as it can assist with ensuring the necessity of a specific medication. The patient, or Eligible Person, may choose to find a more cost effective alternative that is therapeutically equivalent, resulting in cost savings for the Plan Sponsor while maintaining quality patient care. Provider must disclose to each Eligible Person the Patient Pay Amount prior to dispensing the prescription so the Plan Participant has the opportunity to make an informed decision. Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system and in accordance with section 4.05 U&C Validation of the Provider Manual. Provider must keep evidence of the collection of Patient Pay Amount for review.

Provider has the right to provide an Eligible Person with information about the cost of his or her medication, including lower cost alternatives to assist the Eligible Person in finding affordable, clinically appropriate, alternative medications.

All collection of Patient Pay Amounts must occur at Provider’s location; Provider must not outsource the collection of Patient Pay Amounts or submit claims to Caremark for which the collection of Patient Pay Amounts were performed by another entity (e.g., a pharmaceutical hub) unless otherwise authorized in writing by Caremark.

In the event the first documented effort to collect a Patient Pay Amount is initiated after Provider’s receipt of a Caremark audit notice, such collection effort and any thereafter shall not qualify as reasonable efforts to promptly collect Patient Pay Amounts, regardless of any resulting collection of the Patient Pay Amount. Rather, Provider shall be deemed to have waived the Patient Pay Amount in violation of this Collection of Patient Pay Amounts section. The foregoing shall not apply to efforts undertaken by Provider to collect Patient Pay Amounts that are initiated within thirty (30) days of the date of the prescription fill.

3.03.02 Usual and Customary Price
Provider is required to submit accurate U&C Prices for all Caremark claims, including U&C Prices which are part of a standard set price generic program offered by Provider (i.e., program that is open and requires no enrollment). Provider must disclose to each Eligible Person Provider’s U&C Price, including if such U&C Price is less than the applicable Patient Pay Amount.

3.03.03 Coupons and Other Programs
As used in this section, “Pharmaceutical Manufacturer Coupon” means any item or mechanism, including but not limited to, paper coupons, copay cards, e-vouchers, mail-in rebates, and electronic coupon codes funded by a manufacturer, repackager or supplier of pharmaceutical, chemical or compounding products, that reduces the portion of the Patient Pay Amount that an Eligible Person is required to pay for a Covered Item.
Provider must follow specific requirements to use a Pharmaceutical Manufacturer Coupon program to reduce the Patient Pay Amount.

1. Pharmaceutical Manufacturer Coupons may be accepted by a Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:
   a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program, including but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental healthcare program;
   b. The application of the Pharmaceutical Manufacturer Coupon was not performed by another entity (e.g., a pharmaceutical hub) or at a location other than at Provider’s location;
   c. The Covered Item is not a compounded drug, 510(k) cleared medical device or Medical Food.

2. In addition, only certain Covered Items may have Pharmaceutical Manufacturer Coupons applied to reduce the amount the patient is required to pay. The following categories of Covered Items are the only ones where a coupon may be used.
   a. The Covered Item is approved by the U.S. Food and Drug Administration (FDA) through a New Drug Application (NDA) or Abbreviated New Drug Application (ANDA), and is published in the Approved Drug Products with Therapeutic Equivalence Evaluations (or commonly known as the “Orange Book”); or
   b. The Covered Item has a Biologics License Application (BLA), including drugs classified as biosimilars approved under section 351(k) of the Public Health Service Act, and is published in the Lists of Licensed Biological Products (or commonly referred to as the “Purple Book”); or
   c. The Covered Item is an Over-the-Counter (OTC) Covered Item marketed under an official final OTC monograph; or
   d. The Covered Item is a grandfathered drug marketed pre-1938 or pre-1962, or is otherwise Generally Recognized as Safe and Effective (GRASE) by the FDA.

Provider must be able to provide evidence of appropriate coupon use. Provider should review the multiple resources available in order to determine if a coupon can be used to reduce the Patient Pay Amount in accordance with the above requirements.

FDA approved drugs are searchable on the Orange Book at the following website which might be updated from time to time:

www.accessdata.fda.gov/scripts/cder/ob/index.cfm

Similarly, information related to “Purple Book” status can be found at the following website which might be updated from time to time:


Covered items that are FDA cleared may not be used in conjunction with a coupon to reduce the Patient Pay Amount. A searchable database to review a listing of these items is available at the following website which might be updated from time to time:

www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm

Pharmaceutical Manufacturer Coupons that are only eligible to be used at specific pharmacies are not allowed. Certain Pharmaceutical Manufacturer Programs are specifically disallowed, including but not limited to, those from Affordable Medication Solutions, RetainRx, RxData Resources PBM, Phoenix PBM and all associated programs, including but not limited to, The Association for Precision Pharmacy Services and Arena Health Foundation.

Provider’s application of a Pharmaceutical Manufacturer Coupon to reduce a Patient Pay Amount in violation of this section constitutes a prohibited waiver of the Patient Pay Amount.

### 3.03.04 Proof of Payment

Provider must maintain proof of payment by Eligible Person of the Patient Pay Amount [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash], which shall be subject to Caremark audit.

If the Patient Pay Amount is reduced due to a coordination of benefits, Provider must provide evidence of the claim adjudication to the secondary payer.
3.03.05 Documentation
Provider must maintain documents to demonstrate its compliance with terms of section 3.03 Patient Pay of the Provider Manual, and Provider agrees that such documentation is subject to Caremark audit.

3.03.06 Excess Collections
If Caremark determines that Provider has charged or collected from an Eligible Person in excess of the Patient Pay Amount communicated by the claims adjudication system, Provider must promptly reimburse Eligible Person for the excess amount upon Caremark request; otherwise, Caremark reserves the right to recover the excess amount from Provider (including by offset against other amounts owing to Provider) and return the recovered amounts to the Eligible Person.

3.03.07 Limitation on Collection
Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including non-payment by or bankruptcy of a Plan Sponsor or Caremark or where such amount is disallowed or not permitted by a governmental body. For claims of Plan Sponsors who are Medicare Advantage organizations providing Medicare Part C services, Provider must not hold any Eligible Person liable for payment of any fees that are the legal obligation of such Medicare Advantage organization.

3.03.08 Violations
Any act, omission, or scheme that encourages or allows conduct resulting in a violation of section 3.03 Patient Pay of the Provider Manual, such as but not limited to, pharmacy-sponsored coupons, advertisements, pamphlets, flyers, and website postings promoting waiver of Patient Pay Amounts, is strictly prohibited and may result in the immediate termination of the Provider Agreement and other remedies available to Caremark. Claims submitted in violation of this section are subject to chargeback. Provider agrees that absent the waiver or reduction of Patient Pay Amount, the prescription would not have been dispensed.

3.03.09 Patient Inducements
Provider may not offer or provide any item of value, including but not limited to, gift cards, coupons, or free goods or services, to an Eligible Person to induce or reward the purchase of Pharmacy Services or Covered Items from Provider, unless such items are nominal in value (meaning a value of $15 or less) and the aggregate value of items given to an Eligible Person does not exceed $75 per year, as documented in Provider’s records that are subject to audit. Further, notwithstanding the foregoing, Provider may not offer or provide any inducement to an Eligible Person that is prohibited by any applicable Law. This section does not apply to Pharmaceutical Manufacturer Coupons which are addressed separately in the Provider Manual.

3.03.10 Waivers
Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system unless otherwise authorized in writing by Caremark or except for a non-routine, unadvertised waiver of a Patient Pay Amount that does not violate applicable Law and is either:

- A waiver based on an individualized determination of financial need made under a Financial Hardship Program that meets the Financial Hardship Program requirements set forth below; or
- A waiver made following exhaustion of reasonable collection efforts, such as invoices, billing letters, and collection calls.

Provider must document its reasonable collection efforts, and such documentation must include, at minimum, the date the collection effort was sent or contact made, the Patient Pay Amount owed by Eligible Person, results of each collection effort, and final disposition.

If a payment plan is agreed to by Provider with an Eligible Person for the payment of a Patient Pay Amount, all terms of the payment plan, including the total amounts subject to the payment plan and repayment terms, must be documented and written confirmation of such terms must be sent to the Eligible Person. The payment plan must be reasonable and expected to result in full collection of outstanding Patient Pay Amounts owed and must be readily retrievable upon request from Caremark.

3.03.11 Financial Hardship Program
Waivers based on an individualized determination of financial need under a Financial Hardship Program must meet the following requirements.
1. The terms of the Financial Hardship Program must be set forth in a formal written policy adopted by Provider. The policy must specify the documentation required to establish financial need, the criteria for determining eligibility for financial hardship relief and the level of relief to be provided, the application review and approval process, and recordkeeping requirements.

2. Eligible Persons seeking relief under the Financial Hardship Program must submit an application and provide reasonable and objective documentation of financial need that includes federal tax returns and other appropriate documentation.

3. The criteria for determining eligibility for financial hardship relief and the level of relief to be provided must be reasonable.

4. Written notice of qualification for financial relief under the Financial Hardship Program must be provided in writing to the Eligible Person. This notice must specify the amount or portion of the Patient Pay Amount that is being waived and the period of the waiver.

5. Eligibility for continued financial relief under the Financial Hardship Program must be reviewed on at least an annual basis. This review shall be based on a current and updated application and supporting documentation provided by the Eligible Person.

6. Records must be maintained for each Eligible Person receiving financial hardship relief under the Financial Hardship Program. The records must include, at a minimum, the application and supporting documentation submitted by the Eligible Person and a copy of the notice of qualification sent to the Eligible Person.

7. Provider personnel providing final financial hardship approval must be employed by Provider and shall not be contractors or agents of Provider. The identity of the personnel granting approval must be documented and provided as requested by Caremark.

8. The Financial Hardship Program may not be advertised or promoted.

9. The Financial Hardship Program may not be funded, in whole or in part, by any third party.

10. The Financial Hardship Program must meet all requirements and restrictions of applicable Law.

3.04 Standards of Operation

Participation in Caremark’s retail networks is limited to pharmacies or dispensing practitioners that are defined as a “Retail Pharmacy”. A “Retail Pharmacy” is defined as either (1) a duly licensed and established community pharmacy that serves walk-in patients and dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale; or (2) a duly licensed dispensing practitioner that serves patients with whom the dispensing practitioner has a physician-patient relationship and dispenses and sells specialty or non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. For additional information regarding dispensing practitioners refer to Appendix J of the Provider Manual.

Not considered “Retail Pharmacies”:

1. For purposes of this definition, any Provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, whose number of claims submitted to Caremark for prescriptions that were delivered to Eligible Persons (including common carriers such as USPS, FedEx, UPS or other delivery service) exceeds twenty percent (20%) of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. In such case, Caremark reserves the right to exclude such Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or apply other unique terms and conditions to such Provider’s participation in such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing. Caremark further reserves the right to chargeback any improper or excessive payments made to Provider based upon its representation as a retail pharmacy.

2. For purposes of this definition, any Provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, whose number of claims submitted to Caremark for specialty drugs exceeds twenty percent (20%) of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. If Provider has misrepresented itself as a Retail Pharmacy and/or modifies its operations such that it no longer meets the definition of a Retail Pharmacy, in addition to all other rights and remedies, Caremark reserves the right to exclude such Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or apply other unique terms and conditions to such Provider’s participation in such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing.

3. For purposes of this definition, any Provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location, who is owned by a 340B covered entity or whose volume of claims filled using 340B Drug Pricing Program acquired or replenished drugs is the basis for any pharmaceutical manufacturer denying pharmaceutical rebates for claims filled by Provider, is not considered a Retail Pharmacy. In such case, Caremark reserves the right to apply unique terms and conditions to such Provider’s participation in any retail network(s) in which the Provider is participating or any new retail network(s)
established, or such network(s) for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing. All Providers must maintain their NCPDP online provider ID profile services question on 340B so that it is accurate and up to date.

3.05 Records

3.05.01 Documents and Records Maintenance
Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons and Pharmacy Services in accordance with applicable Law and as required by the Provider Agreement, including section 8. Professional Audits of the Provider Manual.

Provider must maintain its prescription records, books, other documents, and any other items for six (6) years or longer, as required by applicable Law, and shall make them available for review. Records must be kept in their original format for the time period required by applicable Law, if any. For the remainder of the required retention period, subject to applicable guidance, Provider may then transfer such prescription records to an electronic format that replicates the prescription hard copy for the remainder of the retention period.

Provider agrees to make its books and records available for a period of ten (10) years from the termination date of the Provider Agreement.

Refer to section 10. Medicare Part D of the Provider Manual and the Federal and State Laws and Regulations (available on the Caremark Pharmacy Portal) for other document and records maintenance requirements.

Provider must maintain and secure records in accordance with HIPAA requirements, including disposing of any records containing Protected Health Information (PHI) in a secure manner in accordance with guidelines issued by the Secretary of Health and Human Services for rendering such records unusable, unreadable or indecipherable to unauthorized individuals.

3.05.02 Signature Log – Hard Copy or Electronic
Provider must maintain a third-party signature log – hard copy or electronic. The third-party signature log must be in date order, readily accessible, and retained for ten (10) years from date of signature or such period as required by applicable Law and must meet the following criteria:

1. Contains a signature which can be individualized or directly related to each prescription dispensed (e.g. prescription number)
   a. For each claim adjudicated through the claims adjudication system, Provider must obtain the signature of the Eligible Person (or his or her authorized representative) on a dated third-party signature log to confirm that he or she has received the medication recorded.
   b. Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.

2. Maintains the date of the receipt of medication by the Eligible Person
3. Maintains a disclosure to Eligible Person of insurance billing
4. Retrievable for the purposes of audit

Third-party signature log options for mail-delivered prescriptions dispensed in accordance with the Agreement include:

1. If delivered to a home or business address, Provider must maintain:
   a. Patient Pay Amount collection documents
   b. Shipping method
   c. Date of shipment or delivery
   d. Shipment manifest
   e. Medication protection method
   f. Documentation of each prescription number and Covered Item delivered including delivery date

2. Tracking documentation for each Covered Item that was delivered.

If Eligible Person is sent monthly billing statements, Provider may insert a form listing the dates of fill and prescription numbers; the Eligible Person or authorized representative should be instructed to sign, date and return the form with his or her payment.

3.05.03 Prescription Information
All prescription documentation (including electronic records within Provider system and written, faxed, telephoned, and computer-generated orders) for Covered Items written by the Prescriber and dispensed to the Eligible Person, must fulfill the requirements as set forth within applicable Law and contain additional information necessary for proper submission and adjudication of a claim transaction such as:
Pharmacy Services and Standards

- Full name of the patient for whom the prescription was written by the Prescriber and the address at which the patient resides
- Full name, address, telephone number, and NPI (or other required identification number) of the Prescriber
- Name, quantity and strength of the medication prescribed
- Specific dosage directions
- Generic substitution instructions (if applicable)
- Notation when patient requests that a multi-source brand medication be dispensed
- If prescription is changed, notation of the changed prescription element, time, date, name of authorizing person, and affiliation with Prescriber
- Refill instructions
- Miscellaneous or other information as required in accordance with applicable Law
- Prescription hard copies or electronic prescription records for insulin and diabetic supplies must contain complete documentation of items, quantities dispensed and directions for use

Documentation for a claim transaction which includes vaccine administration must be maintained on the prescription hard copy or electronic prescription record, or in the form of a vaccination administration record (when the administration was included within the claim transaction). Documentation must include:

- Detail regarding the administration (e.g., lot number, expiration)
- Date of the administration
- Name and NPI of Provider directly responsible for administration of the vaccine; if the Provider does not have an NPI, provide the NPI of the pharmacy
- NPI of the Prescriber of the vaccine, following applicable state and federal Law (this may be the same as the Provider administering the vaccine where applicable Law allows)
- Acknowledgement that confirms the Eligible Person received both the medication and the administration

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy, electronic prescription record or Provider systems where it can be readily retrievable.

During the audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, Caremark recommends that Provider document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the Caremark auditor or help to resolve an audit discrepancy.

3.06 Referrals

3.06.01 Referral Fees
Provider shall not offer or pay to any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referrals of patients or other individuals to Provider for the provision of any pharmacy or other healthcare service.

Provider shall not solicit or receive from any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback or other consideration, whether in the form of money or otherwise, as compensation or inducement for Provider’s referral of patients or other individuals for the provision of any pharmacy or other healthcare service.

3.06.02 Referrals to Non-Retail Participating Providers
Provider must refer Eligible Persons to mail order, specialty, and/or other specified pharmacies for certain Pharmacy Services as appropriate for his or her plan benefit design and in compliance with applicable Law.
4. Claims Submission

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Notwithstanding anything to the contrary in the Agreement, by participating in a Caremark network Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Agreement unless professional judgment dictates otherwise. Provider agrees that any violation of this section is subject to audit chargeback, non-compliance fees, and/or possible termination as a Provider.

A paid claim as indicated through the claims adjudication system is not an indication by Caremark of Provider’s compliance with the Agreement.

4.01 Payer Sheets and Reject Codes

Provider should carefully review the payer sheet referenced in Appendix A and located at www.caremark.com/pharminfo since the submission of certain optional data elements in the most current NCPDP version is required by Plan Sponsors or state and federal programs and must be submitted for processing. Caremark utilizes NCPDP reject codes. Refer to Appendix B of the Provider Manual for additional information.

4.02 General Claim Submission Policies

The following are general Provider claim submission policies that are applicable to all claim submissions:

1. Each claim constitutes a representation by Provider to Caremark that the Pharmacy Services were provided to the Eligible Person and that the information transmitted is accurate and complete. Submission of incomplete, false, or fraudulent claims is a willful misrepresentation and intentional misconduct by Provider.
2. Unless required by Law or regulation, Provider must not submit claims to any other administrator when documentation confirms Eligible Person’s eligibility with Caremark.
3. Unless otherwise permitted by applicable Law, each claim submitted must be for a prescription for a Covered Item that was written by a Prescriber and for which Pharmacy Services for a Covered Item were provided to the Eligible Person for whom the prescription was written.
4. If Provider knows or reasonably should know, that there is not a legitimate Prescriber/patient relationship, Provider must verify the Prescriber/patient relationship prior to dispensing and maintain a record of such verification.
5. Provider must receive Eligible Person consent prior to each fill to dispense the prescription, but such consent is not necessary when the Eligible Person personally initiates the new prescription request or refill.
6. Provider must submit all claims for a Covered Item for Pharmacy Services via the Caremark adjudication system to ensure that plan design, quality, and professional practice standards are met, and that safety and drug utilization review (DUR) are applied.
7. All claims must be submitted online using current NCPDP HIPAA compliant format and in compliance with the Provider Agreement, the Payer Sheets, the Provider Manual, and all applicable Laws, rules and regulations. Caremark may require additional information to process a claim.
8. Provider must not take any steps to circumvent plan design or claims edits. Provider must not modify any claim data fields (e.g., reduce quantities or increase days supply) in order to bypass plan edits or Provider Agreement requirements; and Provider must not use an SCC value to inappropriately override a reject.
9. Provider must display all NCPDP messaging to the dispensing pharmacist. It is imperative that Provider review the claim response in its entirety including primary and secondary messages. Please note that this may require viewing additional screens.
10. Any changes to a prescription, including but not limited to, the Covered Item being prescribed or directions for use, must be approved by the Prescriber prior to dispensing. Provider must date and document the Prescriber approval on the prescription hard copy or electronic prescription record.
11. In order to protect the health and safety of the Eligible Person, Provider must review and act upon DUR messages received from Caremark. As well as reviewing and acting upon Caremark’s DUR messages, Provider
must perform an internal DUR on each claim to monitor for safety concerns such as drug-to-drug interactions and drug allergy monitoring. Refer to section 5. Clinical Programs, Services and Related Messages of the Provider Manual.

12. Providers must inform Eligible Persons about the proper storage, dosing, utilization, side effects, potential interactions, and use of the medication dispensed within professional practice guidelines.

13. Provider must include all eleven (11) digits of the correct National Drug Code (NDC) as dispensed even if the manufacturer of the product only indicates ten (10) digits. The NDC must be provided in a 5-4-2 format. Provider must zero-fill to the left when a number has been excluded from the format. Claim submissions utilizing an NDC other than the NDC of the Covered Item dispensed are subject to audit review and chargeback and are not eligible for reimbursement.

14. All Covered Items, including Over-the-Counter (OTC) Covered Items, dispensed via a prescription that are provided to an Eligible Person as prescribed by a Prescriber must be labeled for the Eligible Person.

### 4.03 Other Claim Submission Requirements

1. **Quantity Dispensed and Days Supply:** Provider must submit the accurate days' supply and quantity on all claims prior to dispensing.
   a. Provider must submit only the quantity indicated on the prescription. Provider must enter the exact metric decimal quantity dispensed (no rounding) on all claim transactions. Provider must submit the quantity based on product description (e.g., kit, volume of medication in milliliters, weight in grams, eaches, number of capsules/tablets). If the quantity is uncertain, Provider must contact the Prescriber to determine the appropriate amount to dispense and note on the prescription hard copy or electronic prescription record.
   b. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
   c. Provider must not adjust the quantity dispensed to circumvent adjudication edits, reimbursement structure, prior authorization edits, clinical program or benefit design edits based on day supply.
   d. If the Prescriber indicates ambiguous direction such as “use as directed” or “as needed,” (e.g., a drug that may be administered on a sliding scale, such as insulin, or a topically applied drug), the Provider must obtain the dosing schedule, dosing range, area of application, frequency, and any other information necessary or applicable to determine the days supply for the quantity dispensed. For example with topical products, the FTU (fingertip-unit) chart is a common reference used to estimate the amount of topical product required based on the area of coverage.
   e. Directions and/or area of application may be obtained from either the Eligible Person or the Prescriber and must be notated on the prescription hard copy or electronic prescription record.
   f. Provider must not combine Prescriber authorized refills.
   g. Provider must consider product expiration and manufacturer storage recommendations when calculating days supply for claim transmission.

2. **Strength Dispensed:** The strength of the medication identified on the claim must be an accurate reflection of that which was prescribed or documentation of the unavailability of the prescribed strength will be required. Provider must utilize the strength originally prescribed by the Prescriber or use an available higher strength single dose of the same medication as described in section 5.08 Dose Optimization of the Provider Manual. Provider must not utilize a lesser strength in an increased quantity without documentation of unavailability of the prescribed strength.

3. **Plan Limitations Exceeded:** Claims submitted to Caremark that exceed Plan limits for the days supply or quantity dispensed will reject with the message, “Plan Limitations Exceeded.” The reject message includes the actual limits such as, “Maximum Days Supply = 34” or “Quantity Limit = 100.” Any claims resubmitted must be entered with the accurate quantity and days supply; however, if the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-day supply), and rejects as stated, it is allowable for Provider to resubmit the claim utilizing that quantity and the maximum days supply as provided in the reject messaging. Provider maintains responsibility to adhere to appropriate refill intervals based on the quantity dispensed and actual days supply (based on the prescribed dosing schedule). For additional information regarding Medicare Part D Claims, refer to section 10. Medicare Part D of the Provider Manual.

4. **Ingredient Cost and Package Size:** Provider is obligated to submit claims using the lowest ingredient cost dosage form and the lowest cost package size container available that results in the lowest reimbursement.

5. **Ophthalmic Products:** Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. A chart to assist in calculating the appropriate days supply for a claim is provided in Appendix D of the Provider Manual.
6. **Drugs with Unusual Submission Requirements:** Claims for some drug products frequently result in incorrect reimbursement. To avoid audit chargebacks, refer to the examples in Appendix of the Provider Manual.

7. **Repackaging:** Claims for repackaged, relabeled NDCs submitted to Caremark that result in higher reimbursement than claims for non-repackaged, relabeled NDCs may be subject to recoupment.

8. **Non-Covered Items:** Claims submitted to Caremark in accordance with a Plan Sponsor program to allow limited dispensing of a non-covered item (e.g., 3-day supply approved for a drug on prior authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable day supply.

9. **Federal Health Care Programs Prescriber Participation Exclusion:** Provider must not submit any claim to Caremark for a prescription prescribed, or item or service furnished, by a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other Federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions and claims for items or services furnished by an excluded or debarred Prescriber, and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment.

10. **Auto-Ship Refill Programs:** Claims submitted for auto-refill programs must only be for medications used in a maintenance therapy. Refer to section 10.04.05 Auto-Ship Refill Programs of the Provider Manual.

11. **Prescription Date:** Each prescription claim transmitted must indicate the actual date of fill; billing of claims must not be pre-dated or post-dated. Date of fill is the date on which the Covered Item is prepared and readied for dispensing to the patient. Provider must not bill claims for prescriptions that are not prepared and available for dispensing. If the actual dispense date exceeds seven (7) days from the date of fill submitted to Caremark, the claim must be reversed and reprocessed with the actual dispense date.

12. **Prescription Not Received; Reversal of Claim:** All prescriptions not received by an Eligible Person must be returned to stock and reversed within fourteen (14) days from original submission through the electronic claims system. Provider must ensure that a reversal response is received from Caremark for any claims representing non-dispensed medications. Refer to section 4.16 Electronic Submission, Reversal, and Processing Windows of the Provider Manual.

13. **Pre-Printed Prescriptions:** Provider must not use pre-printed prescriptions that result in the dispensing of Covered Items that are not the most cost-effective even if they are different salts, bases, release characteristics, or additional drugs in combination.

14. **Test Claims:** Unless otherwise authorized in writing by Caremark, Provider must not submit test claims when a prescription order does not exist (e.g., to determine reimbursement rates). Provider must also not submit test claims acting as a HUB service provider unless given written consent by Caremark.

15. **Vaccines:** When administering vaccines, submit ‘MA’ (for Medication Administration) in the Professional Service Code field (440-E5) of the DUR/PPS Segment along with a positive incentive fee amount in the Incentive Amount Submitted field (483-E3) of the Pricing Segment when administering vaccines. Providers must be certified and/or trained to administer vaccines. Provider is responsible for verifying with individual state boards of pharmacy to determine if pharmacists can administer vaccines.

16. **Durable Medical Equipment (DME):** Provider must only submit DME claims that are payable under the Plan Sponsor’s pharmacy benefit. Provider must submit a valid NDC for the DME. If no NDC exists for a DME, Provider must not submit a claim.

### 4.04 Dispense as Written Codes

Provider must dispense a generic drug whenever permitted and in accordance with applicable Law. Provider must use its best efforts to carry out Caremark and Plan Sponsor mandatory generic programs. In doing so, Provider must contact the Prescriber to encourage a change to a generic substitute when the prescription contains a “dispense as written” signature for a multi-source brand medication.

To ensure proper payment to Provider and the correct Patient Pay Amount of Eligible Persons, Provider must submit all claims with the accurate Dispense as Written (DAW) code, unless otherwise specifically directed by Caremark. Provider must select from the following codes:

- **DAW 0—No Product Selection Indicated**
  - Use DAW 0 when dispensing a generic; that is, when no party (e.g., neither Prescriber, pharmacist, nor Eligible Person) requests the branded version of a multi-source product.
  - Use DAW 0 when dispensing a single-source brand product.
  - Generic pricing may be applied to claims for multi-source products submitted with DAW 0.
DAW 1—Physician Requested Product Dispensed As Written
- Use DAW 1 only when the Prescriber specifies the branded version of a multi-source product on the prescription hard copy or in the verbally communicated instructions (must be evidenced on the prescription hard copy – original and updated); this documentation must occur prior to Pharmacy Services being rendered.
- Computer systems that default to DAW 1 may result in discrepancies and chargebacks.
- Prescription must follow state substitution Laws.

DAW 2—Substitution Allowed—Patient Requested Product Dispensed
- Use DAW 2 when the Eligible Person requests the branded version of a multi-source product even though a generic is available and the Prescriber has authorized (or not prohibited) a generic, or when the Eligible Person requests that Provider contact the Prescriber to obtain approval for a branded version when neither the original prescription nor the verbally communicated instructions specified the branded version.

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed
- Use DAW 3 when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed.

DAW 4—Substitution Allowed—Generic Not In Stock
- Use DAW 4 when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy.

DAW 5—Substitution Allowed—Brand Dispensed As Generic, Priced As Generic
- Use DAW 5 when dispensing a branded version of a multi-source product as a generic.

DAW 6—This Value Is Used As Communicated By Caremark

DAW 7—Substitution Not Allowed—Brand Mandated By Law
- Use DAW 7 when Law or regulations prohibit the substitution of a brand product even though generic versions of the product may be available in the marketplace.

DAW 8—Substitution Allowed—Generic Not Available
- Use DAW 8 when generic substitution is permitted and the brand product is dispensed because the generic is not currently manufactured, distributed or is unavailable in the marketplace.

DAW 9—Substitution Allowed By Prescriber but Plan Requests the Brand
- Use DAW 9 when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted, but the Plan Sponsor’s formulary requests the brand product.

4.05 U&C Validation
Provider is required to submit accurate U&C Prices for all Caremark claims, including U&C Prices which are part of a standard set price generic program offered by Provider (i.e., program that is open and requires no enrollment). Provider must provide, upon request, a record of the dispensing of a prescription (identical to the prescription being audited) that was dispensed to a cash paying customer on the same date if such dispensing occurred. Provider may redact confidential patient health information from the record in accordance with applicable Law, but the record must contain the patient charge amount. Caremark has the right to review and audit documentation and records as detailed in this section to validate that Provider’s submitted U&C is in accordance with the Agreement.

Provider must not modify its U&C, “gross amount due” (as defined by current NCPDP standards), or ingredient cost claimed on individual claims in order to bypass plan edits or Provider Agreement requirements.

4.06 Over-the-Counter Products
Caremark requires a prescription for Over-the-Counter (OTC) products submitted for reimbursement, except in OTC programs as stated below, and Provider must label and dispense the OTC product in accordance with the prescription and applicable Law. The requirements in sections 7. Compliance Reviews, 8. Professional Audits and 4.13 Prescriber Identification; Prescriptive Authority of the Provider Manual are applicable to all OTC claims.
Some Plan Sponsors elect to offer a program where Covered Items include certain OTC products to be dispensed without a prescription. These programs may incorporate a monthly or quarterly maximum; in which case, in the event Eligible Persons reach the allowed maximum amount covered by the Plan, per time period, Eligible Persons are responsible for any amount over the allowed maximum including cusp claims and claims submitted after the allowed maximum is exhausted for that time period.

Upon notification of approval from Caremark, Provider may submit claims for Plan Sponsor OTC programs that do not require a prescription and do not require labeling of the Covered Item by Provider. Provider, however, must maintain a computer-generated label for the OTC product for Caremark’s audit purposes. Unless otherwise specified by Caremark, Provider may submit Provider’s NPI as the Prescriber identification for these programs for OTC products not requiring a prescription.

### 4.07 Multi-Ingredient Compound Processing

The following are submission policies for multi-ingredient compound processing:

1. All compounds must be submitted online in the most current NCPDP version format. Caremark payer sheets can be found online at [www.caremark.com/pharminfo](http://www.caremark.com/pharminfo).

2. Provider must submit the accurate dosage form of the final compounded product dispensed in the compound dosage form description code field in the compound segment (must be a valid NCPDP compound segment dosage form value).

3. Enter the total quantity of the final product dispensed in the quantity dispensed field in the claim segment.

4. Enter the calculated cost of the complete compound as the ingredient cost submitted. This calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the Level of Effort (LOE). Caremark, in its sole discretion, will have final determination of professional allowance attributed to claim above the cost.

5. Calculated cost shall not include cost of drug product associated with waste. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.

6. Enter the actual Product/Service ID (e.g., NDC or UPC) of each active and inactive item used in the preparation of the compound in the compound segment, including any consumable item (e.g., capsule). Each applicable Product/Service ID must be entered accurately. Incorrect submission of any single or multiple ingredient(s) may result in chargeback of the entire claim.

7. Provider must submit the actual Product/Service ID (e.g., NDC or UPC) of each Covered/non-Covered Item. For any items in the compound, such items are only reimbursable if Provider provides, upon Caremark’s request, evidence that each of the active and inactive items in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to chargeback.

8. For compounds that require a delivery device as a component of the final medication product, the device must be submitted as an item in the compound segment only when the device has a Product/Service ID (e.g., NDC or UPC) and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.

9. When required, Provider must submit the accurate Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) value for the final compounded product in the route of administration field in the claim segment.

10. Enter the LOE in the DUR/PPS Segment. The LOE must reflect the compound types which are referenced in [Figure 1 – Level of Effort Table](#), unless otherwise communicated by Caremark. Provider must not program one code for all compounds.

**Figure 1 – Level of Effort Table**

<table>
<thead>
<tr>
<th>DUR/PPS (Field 474-8E)</th>
<th>Compound Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Effort</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Single ingredient capsule</td>
</tr>
<tr>
<td></td>
<td>Any combination of commercially available products</td>
</tr>
<tr>
<td>12</td>
<td>Two ingredient capsule/suppository</td>
</tr>
<tr>
<td></td>
<td>Transdermal gel</td>
</tr>
</tbody>
</table>
DUR/PPS (Field 474-8E) | Compound Type
---|---
Level of Effort |  
13 | Three or less ingredient cream/ointment/gel*  
Three ingredient capsule/suppository*  
Two or less ingredient troche*  
Non-complex suspension  
Tablet triturate*  
14 | Topical containing controlled substance  
Three or more ingredient troche*  
Four or more ingredient cream/ointment/gel*  
Four or more ingredient capsule/suppository*  
Complex suspensions (e.g., pediatric/altering PH/base to salt conversion)  
Chemotherapy cream/ointment/gel*  
Hormone therapy (capsules/troches/suppositories)  
15 | Sterile products - limited to aqueous bronchial and nasal inhalations (does not include nasal sprays or irrigations), injections, irrigations for wounds, and ophthalmic drops and ointments per USP <797>  

*Using bulk (powder) APIs

11. Coverage determination is performed on each and every item in the compound.

12. Provider may receive a rejected response for a compound claim when item(s) within the compound are not reimbursable; Caremark accepts Submission Clarification Code (SCC) 08 (Process Compound for Approved Ingredients) which will result in an adjudicated response on all items.

13. Non-Covered Item(s) within a compound are not reimbursable.

14. Compounds may be a Covered Part D Drug for Medicare Part D Enrollees provided the compound contains at least one Covered Part D Drug. The item cost must only include components which satisfy the definition of a Covered Part D Drug as defined in 42 C.F.R. § 423.100. Components that are not Covered Part D Drugs as defined by the Centers for Medicare and Medicaid Services (CMS) may be included in the creation of the product, but may not be included in the calculation of the item cost submitted (e.g., sterile water, compounding bulk powders, vitamins, components not utilized for a diagnosis recognized in the compendia). Provider must, however, include all items used in the creation of the compounded product on the multi-ingredient claim transmission.

15. If compounded claims reject for pricing edits (e.g., exceeds maximum cost for the Plan), Provider must not alter the quantity or identity of the individual components submitted to inappropriately enable reimbursement. Provider must not alter the quantity of, or omit an item dispensed to circumvent Caremark's reimbursement structure, such as providing only 83 days of a 90-day supply prescription or dispensing monthly, but billing weekly.

16. Provider must not manipulate claims pricing or the compound indicator for inappropriate financial gain or cause a claim to inappropriately pay.

17. The Caremark adjudicated claim response indicates the total payment for the compound claim. Provider must not balance bill an Eligible Person if prohibited by applicable Law.

18. When a compounded product is dispensed to an Eligible Person, Provider must bill Caremark a single claim for the final compounded product using multi-ingredient functionality (including all active and inactive items used in the creation of the compounded product) and must not bill separate claims to Caremark for individual items or ingredients used in the creation of the compounded product. In an effort to protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.
19. Compounds that have a commercially available product are not reimbursable.
   a. In the event a commercially available product becomes unavailable (e.g., product is on backorder, drug shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
   b. If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount.

20. Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.

21. Compounding must be performed by a qualified person as defined by applicable Law.

22. Outsourcing any portion of Pharmacy Services for compounded medications not approved in advance and in writing by Caremark is prohibited.

23. Refer to section 7.02 Additional Information Regarding Compliance Reviews of the Provider Manual for documentation requirements.

The following must not be billed as a multi-ingredient compound:
1. A combination of products which are not combined to make one final medication for use (e.g., a kit of individual products designed to be used independently)
2. A combination of Covered Items which do not have a medical purpose in combination other than convenient dosage form
3. Any product that contains an item or substance that is classified as a dietary supplement as defined by the Dietary Supplement Health and Education Act (DSHEA) of 1994
4. A commercially available compound kit or commercially available product which is represented by a unique assigned NDC and contains all the items of the final product as such (e.g., kit containing a base and active items and directives for mixture)
5. Compounds dispensed for human consumption or application which include items that are not approved for human use
6. Medications requiring reconstitution prior to dispensing (e.g., powdered oral antibiotics, topical acne preparations, injectable medications)
7. Flavoring of a commercially available product prior to dispensing (e.g., addition of flavor to powdered oral antibiotics), nor should the item cost submitted include flavoring cost
8. Covered Items that are in a ready-to-use form that are transferred from one container to another for use (e.g., pre-filling insulin syringes, transferring multiple bottles into a single IV bag)
9. Any compound that contains a drug product that has been withdrawn or removed from the market because the drug product or components of the drug product have been found to be unsafe or not effective as defined in section 21 C.F.R. § 216.24 of the Code of Federal Regulations

4.08 Overrides
Caremark has developed general prior authorization numbers for some Plan Sponsors for claims that reject. A Pharmacy Help Desk representative can provide information if the Plan Sponsor allows for an override to allow the claim to adjudicate. In addition, some Medicaid Plan Sponsors provide temporary coverage of non-formulary medications. If this is the case, the claim may reject with a message that includes the temporary days supply that will be covered and the prior authorization number to enter into the NCPDP prior authorization number field in order for the claim to adjudicate. Provider must calculate the appropriate quantity for a Covered Item accordingly to correspond with prescription instructions and temporary days supply. Provider must maintain documentation to substantiate any overrides applied to a claim.

4.09 Natural Disasters
Caremark is dedicated to assisting Providers and Eligible Persons in response to emergencies resulting from natural disasters, severe weather, etc. where medical records are either destroyed or not accessible. In the event of a presidential (or other governmental) emergency declaration, Caremark will allow a specific submission clarification code to override the refill-too-soon edit for Eligible Persons impacted within the disaster area. A value of ‘13’ in the Submission Clarification Code (SCC) field, 420-DK, and the displaced Eligible Person’s zip code impacted by the disaster (zip code may not be where Eligible Person resides) in field 325-CP, will allow an override without requiring
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a call to the Pharmacy Help Desk. On the prescription hard copy or electronic prescription record, document the specific declared disaster (e.g., tornado, flood, wildfire), how the member was impacted (e.g., medication damaged, temporary relocation) and the date the disaster override was utilized. Permission may vary by Plan Sponsor. If you need assistance, call the Pharmacy Help Desk.

Refer to section 1.04 Pharmacy Help Desk of the Provider Manual for contact information.

Refer to section 10. Medicare Part D of the Provider Manual for additional information.

4.10 Coordination of Benefits

Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person’s benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any Coordination of Benefits (COB) requirements, and must engage in appropriate COB activities to the extent required by Caremark or applicable Law.

Claim submissions with incorrect COB values are subject to chargeback.

4.10.01 Multiple Transaction Coordination of Benefits

For the majority of plans, Caremark utilizes a typical multiple transaction COB process. Multiple transaction COB consists of one claim submitted to the primary payer followed by one or more claims submitted to the supplemental payer(s). Specific COB RXBINs exist to differentiate between claims that are supplemental to Medicare Part D and claims that are supplemental to non-Medicare Part D coverage.

For COB claims that are supplemental to Medicare Part D, Provider must submit RXBIN 012114 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of Plan-specific claims processing information.

For COB claims that are NOT supplemental to Medicare Part D, Provider must submit RXBIN 013089 unless otherwise communicated by Caremark. Plans offering coverage that is supplemental may require specific COB RXPCNs as communicated or printed on ID cards. Providers may receive notice of Plan-specific claims processing information.

Refer to section 10. Medicare Part D of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets referenced in Appendix A of the Provider Manual.

4.10.02 Single Transaction Coordination of Benefits

Caremark may utilize a Single Transaction Coordination of Benefits (STCOB) process whereby Provider sends one transaction to Caremark and the Claim adjudicates against both primary and secondary plans before returning one final response to Provider. Single Transaction COB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for Eligible Persons. When STCOB is utilized, it is not necessary for Provider to submit a separate COB claim in order to coordinate these benefits.

Refer to section 10. Medicare Part D of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the Caremark Payer Sheets referenced in Appendix A of the Provider Manual.

4.11 Long-Term Care Billing

For information related to Medicare Part D LTC billing, refer to section 10. Medicare Part D of the Provider Manual.

For Providers providing home health care or Long-term Care (LTC) Covered Items to Eligible Persons, each NDC of the individual drug dispensed must be billed only once to Caremark during any 30-day period unless allowed by Plan Sponsors. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws. Provider must submit claims to Caremark’s claims adjudication system for LTC Pharmacy Services.

Provider must bill Caremark once during any 30-day period for medications dispensed continuously over the course of a month for an Eligible Person. One dispensing fee will be paid based on the monthly quantity dispensed of a single drug of a single strength for an Eligible Person. When the medical needs of the Eligible Person require a change in the medication order or the medication provided has a documented medical necessity for limited dispensing (including but not limited to, expiration of product) requiring an additional dispensing of the same drug, Provider may receive one dispensing fee for each new medication order or dispensed quantity limited by medical
necessity. Provider must include within documentation of medical necessity for limited dispensing the diagnosis/clinical reason for the patient need from the Prescriber on the Prescriber’s letterhead or prescription pad/form.

4.12 Dispensing Pharmacy NPI/NCPDP

Unless Caremark expressly authorizes otherwise in writing, Provider must not allow an entity (e.g., a pharmaceutical hub) to use its NPI number, NCPDP number, software certification number or other identifiers to submit a claim (including a test claim) to Caremark.
1. Claims submission must utilize the NPI number or NCPDP number of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person;
2. The Provider that submits the claim to Caremark must be the same Provider that dispenses the Covered Item to the Eligible Person;
3. Provider must not allow an entity to submit a claim on Provider’s behalf using Provider’s or any other identifiers;
4. Provider is not allowed to submit claims on behalf of another entity;
5. Provider must only submit claims it intends to dispense; and
6. Provider may not act on behalf of another entity regardless of ownership structure.

4.13 Prescriber Identification; Prescriptive Authority

Accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claims adjudication, clinical services, Plan Sponsor initiatives, and audits. A valid and active individual Prescriber National Provider Identifier (NPI) is required on all claims, and failure to submit a valid and active Prescriber NPI may result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI, DEA number or any other number or identifier (e.g. hospital, clinic, or pharmacy identification number) in the prescriber identification field which does not represent an individual Prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate submission clarification code (SCC) to bypass the reject.

4.14 Transaction Fees

Caremark charges network Providers, and Provider agrees to pay, transaction fees that represent pharmacy network management services Caremark provides to network Providers. For every single transaction Provider transmits to Caremark, Caremark may deduct such amounts for the transaction fee from amounts payable to Provider. A single transaction is defined as each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims adjudication system. Each transaction within a multi-claim transmission will be subject to individual transaction fees.

4.15 Transaction Submission Resolution Management Service Fees

Caremark charges network Providers, and Provider agrees to pay, fees for Caremark’s resolution of transactions submitted by Provider, including but not limited to, rejected claim resolution, pharmacy compliance, and claims information quality improvement. The fee charged to Provider will be commensurate to the amount of resolution management services Caremark is required to expend based on Provider’s claims submissions, as measured comparatively to all other Providers on a retrospective monthly basis. Caremark will determine how the fee will be measured and assessed, as communicated to network Providers in writing accordingly. The Transaction Submission Resolution Management Service Fee charged will be charged per transaction, and Provider has the opportunity to reduce the amount of fees charged based on the degree of resolution of transactions required by Caremark for Provider as compared to all other Providers. Caremark may deduct the fee amount from amounts payable to Provider. Providers will be charged for either a Transaction Fee (as described in section 4.14 Transaction Fees of the Provider Manual) or a Transaction Submission Resolution Management Service Fee, but not both for the same transaction.

4.16 Electronic Submission, Reversal, and Processing Windows

Unless otherwise agreed in writing and to the extent consistent with applicable Law, all claims must be submitted electronically. Failure to submit a claim within ninety (90) days from the date of fill may result in non-payment of such claim to the extent consistent with applicable Law.

All prescriptions not received by an Eligible Person must be returned to stock and claim must be reversed within fourteen (14) days from original submission through the electronic claims system using data elements as defined
Claims Submission

by Caremark’s payer sheets (found online at www.caremark.com/pharminfo) or as directed by Caremark.

Reversals and resubmits must occur within ninety (90) days of the claim’s original submission date, or such other time period as communicated by Caremark or required by applicable Law. For reversals, Provider can reverse up to ninety (90) days from the date on which the claim was originally submitted, including Plan Sponsor-specific payment cycles. For Medicare Part D processing windows, refer to section 10. Medicare Part D of the Provider Manual.

Except as otherwise required by applicable Law, or in the event of an urgent need to provide service to an Eligible Person while the claims system is unavailable (refer to section 4.18 Schedule of Claims Systems Maintenance of the Provider Manual), Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (e.g., cartridge, CD-ROM, tape, batch or paper) unless prior written approval is received from Caremark or Plan Sponsor. Caremark charges a handling fee of $2.50 per claim in those situations in which Caremark or Plan Sponsor agree in writing to non-electronic submission or reversal of claims.

4.16.01 UCF Requirement

Caremark reserves the right to require Provider to submit claims via a UCF, along with all supporting documentation that Caremark may require to support the claim, including but not limited to, medical records and Eligible Person attestations, at Caremark’s sole discretion.

4.17 Software Certification

Provider must utilize software certified by Caremark and adhere to the NCPDP standards in compliance with HIPAA. Provider must support NCPDP updates as requested from time to time by Caremark. Provider is responsible for and assumes all risk arising from or related to Provider’s selection and use of its software. Provider must indemnify Caremark and its affiliates from and against any claim, cause of action, liability, loss, damage, cost, fines, charges and/or expenses arising from or related to Provider’s selection and use of its software.

Caremark may provide reasonable technical support to assist Provider in complying with Caremark requirements and industry standards for submitting claims through the claims system. Provider may be assessed a fee by Caremark if Provider submits claims that are not in accordance with current requirements, industry standards or in compliance with government program requirements.

Provider must submit all claims with the software certification ID in field 110-AK. Provider must not release their software certification ID to be used by any other software or other user/entity. Any violation of this rule may result in a reject of the transaction as well as the assessment of an administration fee. Refer to section 7. Compliance Reviews of the Provider Manual.

If Provider is not submitting claims in accordance with HIPAA-mandated data and/or standards, Caremark may reject the transaction and/or charge a minimum fee of $0.99 per transaction. In addition, Provider is required to provide Eligible Person(s) a bridge supply of medication(s) until such time occurs when Provider is compliant with HIPAA-mandated data and/or current NCPDP standard, and the claim(s) can be adjudicated.

Refer to the NCPDP standard at www.ncpdp.org/Members/Standards-Lookup.aspx Membership to NCPDP is required to view this information online.

4.18 Schedule of Claims Systems Maintenance

Maintenance of the claims systems may be scheduled between 11 p.m. and 6 a.m. Eastern Standard Time (EST) every Friday or Saturday as necessary. During the scheduled maintenance, Providers will receive the message, “HOST UNAVAILABLE.” If this message displays, Providers must resubmit claims after maintenance is completed.

If maintenance is not needed, Providers will be able to submit claims as usual during those hours. If any other scheduled maintenance is required outside of the published hours listed above, Caremark may notify Provider in advance.

From time to time, unscheduled system maintenance or other circumstances may occur when the adjudication platform(s) may not be available to adjudicate claims for a limited time. At any time, a Provider may contact the Pharmacy Help Desk for assistance or information regarding any claim processing related question. Pharmacy Help Desk Representatives are available 24 hours a day, 7 days a week. Refer to section 1.04 Pharmacy Help Desk of the Provider Manual.

Note: Providers are reminded that, pursuant to the Provider Agreement, Providers must render services unless professional judgment dictates otherwise.
4.18.01 Additional Required Procedures

1. If the claims adjudication system indicates a host processing error or unexpected reject has occurred, Provider should attempt to resubmit within a few minutes. If the status continues to indicate a host processing error (downtime circumstance), Provider should hold the transaction and attempt to process it again within the next two hours.

If two hours have elapsed and the same host processing error or unexpected reject continues to occur, call the Pharmacy Help Desk for additional information regarding system availability and other assistance that may be available at that time. The Pharmacy Help Desk is equipped to assist in guiding the pharmacy through the claim resubmission process when the system becomes available.

2. To ensure that each Eligible Person receives his or her covered prescription drugs, Provider must make reasonable attempts to obtain information necessary to fill a script.

Provider is requested to serve the Eligible Person by establishing/confirming eligibility/coverage:

a. If the Eligible Person is available, ask for the ID card. Call the Customer Care number on the ID card to verify eligibility, drug coverage, formulary status and associated Patient Pay Amount.

b. If the Eligible Person is not available, call the Pharmacy Help Desk.

3. Provider should provide a bridge supply, typically covering three (3) days, for those Eligible Persons in urgent need of medication so that the Eligible Person is not delayed at the pharmacy counter during a system downtime event, or provide service to the Eligible Person and submit a Universal Claim Form (UCF) within the required timeframe.

4.19 Taxes

For purposes of this Section, the term “Provider Taxes” shall include any provider fees, assessments, sales taxes, transaction privilege taxes, occupation taxes or similar fees/taxes imposed by any federal, state or local governmental authority.

Provider is responsible for submitting requests for reimbursement/payment of Provider Taxes for claims requiring such inclusion at the time of the claims submission. In no event shall Caremark be responsible for any Provider Taxes or other liability that may be imposed on Provider. Provider shall be responsible for timely filing any reports or returns and for timely paying all Provider Taxes with the appropriate governmental authorities. Provider is responsible for submitting accurate and authorized claims for Provider Taxes through adjudication and providing support upon written request. Caremark is not responsible for confirming such Provider Tax amounts through adjudication. Reimbursement of Provider Tax is not confirmation or validation. Provider is responsible for any Caremark or Plan Sponsor losses due to incorrect Provider Taxes submitted for claim adjudication.

To the extent permitted under the terms of its agreement with the Plan Sponsor or as required by Law, Caremark agrees to seek reimbursement/payment from the Plan Sponsor for any timely and accurately submitted claim for Provider Taxes incurred by or imposed on Provider by any governmental authority on account of, or based upon, the provision of Pharmacy Services or Covered Items. Caremark is not responsible for correcting claims for Provider Taxes for which Provider failed to submit Provider Taxes.

An Eligible Person may be liable, in addition to any applicable copayment, coinsurance or deductible, for Provider Taxes, unless specifically prohibited under applicable Law; provided, however, that if the applicable governmental authority otherwise compensates Provider or makes Provider whole for any such Provider Taxes, Eligible Person shall have no obligation to reimburse Provider for the amount of Provider Taxes so compensated.

In no event does this section give Provider any additional rights than those allowed by Law.
5. Clinical Programs, Services and Related Messages

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Provider must support all clinical programs and services and utilize software that will display all messages related to clinical programs and services and that provide for the recording of patient drug and medical information where utilized by Caremark and as allowed by applicable Law.

Subject to applicable Law, Provider must provide Caremark any and all reasonably available information that Caremark needs to perform such clinical programs and services, and conduct drug utilization review accordingly. Provider must act upon all messages related to clinical programs subject to professional judgment.

5.01 Drug Utilization Review

Inappropriate drug therapy can cause patient injury and can lead to additional health care costs. In an effort to reduce the number of situations where an Eligible Person may receive inappropriate drug therapy, Caremark implemented a concurrent Drug Utilization Review (DUR) program that detects a potential therapeutic problem at the point of service.

In order to ensure that Provider receives and acts upon all DUR messages, which appear in the claim response, Provider must adhere to the claims submission requirements outlined in section 4. Claims Submission of the Provider Manual.

The functions of the DUR program are to:

- Analyze prescriptions submitted through Caremark
- Screen prescriptions for several types of therapeutic drug problems
- Serve as a clinical information service

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional judgment of the Provider or Prescriber. The Provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims system and for performing Pharmacy Services in each jurisdiction consistent with the scope of their respective licenses.

Additional information regarding DUR review controls for Medicare Part D claims may apply as specified by Caremark.

5.02 DUR Conflict Codes and Messaging

All DUR messages appear in the claim response. The Provider must view all screens necessary to receive the message detail and act upon all such messages subject to the professional judgment of Provider.

Provider will receive DUR messaging in a format consistent with its software vendor. Provider may need to consult with the software vendor for help with identifying or accessing DUR messages. Caremark, in accordance with current NCPDP standards, returns up to nine (9) DUR messages that can be received on the same claim and requires Provider to have the capability to accept up to nine (9) DUR messages on the same claim.

Refer to the NCPDP standard at http://www.ncpdp.org/Members/Standards-Lookup.asp Membership to NCPDP is required to view this information online.

5.03 Refill-Too-Soon or Excessive Utilization Reject

Provider must call the Pharmacy Help Desk if extenuating circumstances justify payment for a claim that was denied for excessive utilization (Refill-Too-Soon). Provider can enter Submission Clarification Codes (SCC) in field 420-DK to override a refill-too-soon reject for Eligible Persons without requiring a call to the Pharmacy Help Desk. Provider must document on the prescription hard copy or electronic prescription record the details of any situation requiring an override. Permission may vary by Plan Sponsor.

Examples of extenuating circumstances include:

- Lost or stolen prescriptions (SCC 04)
- Damaged prescriptions, dropped or broken prescription bottle containing liquid (SCC 04)
Clinical Programs, Services and Related Messages

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

- Vacation supplies (SCC 03)
- Increase in dosing/therapy change (SCC 05)
- Circumstances such as natural disasters. Refer to section **4.09 Natural Disasters** of the Provider Manual.
- Extra supply for school or similar circumstances (e.g., rescue inhalers or epinephrine auto-injectors)

If you need assistance, call the Pharmacy Help Desk.

5.04 Drug-Drug Interaction Reject Program

The Drug-Drug Interaction Reject Program is a point-of-sale claim reject for selected high-risk drug combinations. The reject will occur if the current drug being submitted and another drug that was dispensed to the Eligible Person are one of the high-risk drug combinations included in the program.

When a claim is rejected for a high-risk drug-drug interaction, a standard drug-drug interaction warning message will be transmitted with the claim reject response. In addition, a secondary message will be transmitted that provides instructions regarding override options.

Depending on the types of overrides that the Caremark Plan Sponsor has authorized, one of the following override option messages will be transmitted:

1. **PPS Code REQD: <<Rejection Message>>**
   - In this case, Provider may resubmit the claim with the indicated PPS code to override the reject, based on the professional judgment of Provider and in consultation with the Prescriber.

2. **PA REQD: <<Rejected Message>>**
   - A secondary message will include the PA contact number
   - In this case, a PA is required to override the reject. The message will provide further instructions on how to obtain an override.

Provider must contact the Prescriber to discuss the drug-drug interaction that has been identified for the current prescription based on the Eligible Person’s other active drug therapy. If the Prescriber determines that the prescribed therapy is warranted despite the drug-drug interaction risk, or if the interacting drug has been discontinued, the Provider must pursue an override according to the instructions provided in the claim response message. Otherwise, Provider should obtain a new prescription for an alternative therapy.

5.05 Formularies

Plan Sponsor formularies determine how drugs are covered (e.g., preferred, non-preferred, excluded) for drug therapy selections. The final choice of specific drug selection for an Eligible Person rests solely with the Prescriber.

Provider must support all formulary initiatives and inform Eligible Persons when a non-formulary drug has been prescribed. Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider agrees that for all Plan Sponsors and Eligible Persons, therapeutic programs and formularies take precedence over any agreements or programs to which Provider is a party. Provider also agrees not to implement any substitution programs for Eligible Persons that are inconsistent with such therapeutic programs and formularies.

When a claim is submitted for a non-formulary drug and the Plan has a closed formulary, it may reject with:

**Product Not on Formulary**

or a similar message, which may include a customized drug alternative.

When a claim is submitted for a non-formulary drug and the Plan has an open formulary, the response may include the message:

**NF! Form <<XXX>>**

In many cases, the Patient Pay Amount may be higher for a non-formulary medication.

5.06 Prior Authorization

For some Plans, certain medications will require prior authorization. For prior authorization, the Prescriber is required to supply additional documentation to Caremark or the Plan Sponsor to determine whether certain criteria are met for the drug to be covered under the Plan.

Provider must follow Caremark and Plan Sponsor requirements for the prior authorization process, including but
not limited to, obtaining a Prescriber’s signature on a prior authorization form if a Prescriber signature is required. In no event may Provider represent itself as a Prescriber or a member of Prescriber’s staff as part of the prior authorization process.

If a medication is designated for prior authorization, the claim may reject with the following or similar message:

**PRIOR AUTHORIZATION REQUIRED**
**MD Call <<XXX-XXX-XXXX>>**

In most cases, the claims system response will also provide the correct contact information in the subsequent message.

If in the Prescriber’s professional judgment the drug is medically necessary, Prescriber will need to call the number provided in the claim message to initiate coverage.

For Aetna RXBIN 610502 only: If no contact number is provided in the messaging, Provider should contact the Prescriber and ask him or her to contact the Precertification Unit for precertification and medical exception requests. The Precertification Unit contact information for RXBIN 610502 is:

**Fax:** 1-800-408-2386  
**Phone:** 1-800-414-2386  
**(Hours: Monday through Friday, 8 a.m. to 7 p.m. CT)**

Provider must support all clinical programs and services and inform Eligible Persons when a drug designated for prior authorization has been prescribed. Provider must use its best efforts to contact the Prescriber to inform on prior authorization messaging.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

### 5.07 Managed Drug Limitations/Quantity vs. Time

Some Plan Sponsors implement managed drug limitations (MDL) or quantity vs. time (QVT) programs. MDL or QVT programs allow an Eligible Person to receive up to a set amount of medication per designated timeframe.*

If an Eligible Person presents a prescription for an amount greater than the set amount or has accumulated an amount greater than the set amount within the designated timeframe, the claim will reject with one of the following or similar messages:

**PLAN LIMITS EXCEEDED <<# of quantity left>>**

*If prescribed quantity exceeds the plan parameters, call the Pharmacy Help Desk to verify if Prior Authorization is available.

**MAX QUANTITY XX PER XX DAYS**

If there is a remaining quantity within the designated look-back period and within the Plan parameters, Provider can resubmit the claim after the appropriate amount of time has passed using an amount equal to or less than the amount stated in the message.

**MISSING/INVALID DAYS SUPPLY <<use higher strength one per day>>**

In the event there is an override option, the subsequent message will list next steps:

**CALL HELP DESK <<or a specific Plan Sponsor telephone number>>**

Provider must contact Prescriber for a new prescription of a higher strength at the once-daily dosing regimen, then resubmit the claim with the higher strength. If this cannot or should not be done based on the professional judgment of Provider or the Prescriber is unwilling to change the prescription, review Provider messaging for further instructions.
5.09 Step Therapy

Step Therapy requires that a set quantity of certain medication(s) be in an Eligible Person’s drug history within a given timeframe before a claim will adjudicate for another drug in a specified therapeutic category. If Provider submits a claim for a Step Therapy and the conditions are not met, the claim will reject with a message similar to the below:

NDC NOT COVERED SUBOPTIMAL REGIMEN
USE <<XXXX>> 1ST
MD CALL <<XXX-XXX-XXXX>> FOR PRIOR AUTHORIZATION

If Provider receives this message, discuss the alternatives with the Prescriber. If in the Prescriber’s professional judgment the originally prescribed drug is medically necessary, Prescriber will need to initiate a request for prior authorization.

A qualification period may also be in place for the targeted drug. Once an Eligible Person satisfies the Step Therapy requirements, he or she may obtain the targeted drug for a specific time period (e.g., 60 days). When the qualification period has been exceeded, the Eligible Person must requalify for the prescribed drug by repeating the Step Therapy requirements.

Some Plan Sponsors may choose to give Eligible Persons additional flexibility in choosing not to follow the recommended Step Therapy. A copayment option may be available for some Eligible Persons which allows them to obtain the originally prescribed drug without requiring the Prescriber to call for an override. The Eligible Person may make the decision and obtain the original drug simply by paying a higher copayment.

If this option is in place, claims not meeting the required conditions will reject with the following or similar message:

NDC NOT COVERED SUBOPTIMAL REGIMEN
COPAY = <<XX.XX>>
TO ACCEPT, SUBMIT PA - 99999999999

If you receive this message, discuss the alternatives with the Eligible Person and advise that the originally prescribed drug can be obtained by paying the copayment indicated in the message. If the Eligible Person accepts the copayment, resubmit the claim to Caremark using PA code 99999999999.

5.10 Plan Sponsor Programs

Provider must participate in Plan Sponsor programs as requested by Caremark and/or Plan Sponsors. Provider must maintain internal procedures for compliance with such programs and furnish an outline of such procedures to Caremark upon request. Providers are encouraged to engage in and support Plan Sponsor electronic prescribing initiatives in accordance with applicable Law.

5.11 Federal Regulatory Quality Assurance Programs

Caremark recommends Provider adhere to Federal Regulatory Quality Assurance Programs such as, but not limited to:

- Medication Errors Reporting Program (MERP) through the Institute for Safe Medication Practices (ISMP); more information can be found on the website www.ISMP.org
- MedWatch program through the Food & Drug Administration (FDA); more information can be found by calling 1-800-FDA-1088 or on the web-site www.FDA.gov

5.12 Clinical Studies/Trials

To the extent Provider participates, or is involved, in a study, directly and indirectly, for which Provider submits claims to Caremark for adjudication and payment for prescriptions obtained by study participants (e.g., Eligible Persons), Provider must obtain prior written approval from Caremark. If prior Caremark written approval is not obtained, claims submitted to Caremark for study participants are subject to chargeback. Caremark’s review of the study will be administrative in nature to determine Provider’s compliance with the terms of the Provider Agreement, such as but not limited to, determining whether any compensation paid to study participants has the effect of waiving the participant’s Patient Pay Amounts under the Plan (which Provider has an obligation to collect in accordance with the Provider Manual – see section 3.03.01 Collection of Patient Pay Amounts) or whether study premises result in changes in drug regimens that have the effect of increasing Plan Sponsor costs.

Provider requests for approval must include all of the following details:
Clinical Programs, Services and Related Messages

- Study overview
  - Study duration
  - Number of subjects
  - Study locations
  - Medications involved
  - Costs for participants and Plan Sponsors
- Details of insurance for study
- Credentials of study investigators
- Source of funding for the study
- Consideration paid to all study participants, providers, and prescribers
- Copies of all documentation submitted to ethics committees, review boards, or governmental agencies
- Disclosure of any potential conflicts of interest

Requests for approval can be sent to the following address:

**CVS Caremark**  
**ATTN: Pharmacy IRB Study Review**  
**9501 E. Shea Boulevard, MC-020**  
**Scottsdale, AZ 85260**

The requirements of this section do not apply to FDA-approved clinical trials.
6. Network Participation and Payment

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Caremark, on its own behalf, or on behalf of a Plan Sponsor, reserves the right to limit Provider’s participation in a network to certain Plan Sponsors based on Plan Sponsor network design or contractual rights to determine network participation, including but not limited to, suspension or termination of the Agreement upon a determination by a Plan Sponsor in their sole discretion that Provider has not performed satisfactorily, unless otherwise precluded by applicable Law.

Caremark will reimburse Providers for Pharmacy Services for Covered Services provided as set forth in the Provider Agreement, including any amendments, Network Enrollment Form, exhibits and this Provider Manual. Even if Provider has not signed a rate schedule, Provider is deemed to have accepted participation and the reimbursement rates in any Caremark or Plan Sponsor network in which Provider submits a claim for an Eligible Person in that network. Notwithstanding anything to the contrary in the Agreement, by participating in a Caremark network, Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Agreement unless professional judgment dictates otherwise; provided that Caremark, or Caremark on behalf of a Plan Sponsor, reserves the right to limit Provider’s participation in a network to certain Plan Sponsors based upon Plan Sponsor network design.

Plan Sponsors may make determination about network participation.

Caremark may from time to time enter into an arrangement with a plan sponsor (“Other Entity”) pursuant to which Provider’s Provider Agreement (including reimbursements terms and schedules) with Caremark will be utilized by such Other Entity and such Other Entity’s pharmacy benefit manager (“Other PBM”) on the Other PBM’s adjudication platform, as communicated by Caremark. Provider agrees to cooperate with Caremark, Other Entity, and Other PBM as needed to support such arrangement.

6.01 Provider Payment

Notwithstanding any other provision in the Provider Agreement, in the event of a conflict between the reimbursement rate indicated through the claims adjudication system and a Network Enrollment Form or addendum or any other agreement, the claims adjudication system reimbursement rate will apply provided there is no error in the claims adjudication system resulting in overpayment to Provider or to Eligible Person.

6.02 Reimbursement

Notwithstanding any other provision in the Provider Agreement, claims (excluding compounded medications) submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network may be reimbursed at the lower of:

- Price Type plus an applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee less the applicable Patient Pay Amount (or if applicable Price Type is unavailable for a given drug, Caremark will pay Provider based upon Average Wholesale Price (AWP) minus the applicable AWP Discount plus the applicable Dispensing Fee minus the applicable Patient Pay Amount);
- Maximum Allowable Cost (MAC) plus the applicable Dispensing Fee less the applicable Patient Pay Amount;
- Ingredient cost submitted by Provider plus the applicable Dispensing Fee less the applicable Patient Pay Amount;
- Provider’s U&C price less the applicable Patient Pay Amount; or
- Provider’s submitted “gross amount due” (as defined by current NCPDP Industry Standards) less the applicable Patient Pay Amount.

Reimbursement will be set forth in a Network Enrollment Form, network addendum, or transmitted online via the adjudication claims adjudication system.

Compounded medications submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of:

- Ingredient cost submitted minus applicable Patient Pay Amount plus Dispensing Fee plus applicable Level of Effort (if submitted) amount (provided Provider accurately submits the ingredient cost submitted in accordance with the Provider Manual);
Network Participation and Payment

- Provider’s U&C price less the applicable Patient Pay Amount;
- Plan Sponsor-specific reimbursement less the applicable Patient Pay Amount; or
- Provider’s submitted “gross amount due” (as defined by current NCPDP Industry Standards) less the applicable Patient Pay Amount.

Unless otherwise required by a Plan, Provider may retain the differential between Eligible Person’s Patient Pay Amount and Provider’s contracted reimbursement amount with Caremark.

6.03 Changes to AWP

In the event Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) discontinues the reporting of Average Wholesale Price (AWP) or changes the manner in which AWP is calculated, then Caremark reserves the right to modify the pricing terms of the Provider Agreement, notwithstanding any other provision in the Provider Agreement. Such modification may include:

- Modification of the AWP unit price reported by Medi-Span (or any other similar nationally recognized reference which Caremark may reasonably select from time to time) by applying the Wholesale Average Cost (WAC) Mark-Up factor (in use before the effective date of a change in the calculation of AWP) to the WAC unit price reported by Medi-Span (“Pre-Settlement AWP Discount”);
- Utilization of a modified AWP Discount (“Post-Settlement AWP Discount”); and/or
- Utilization of alternate Price Type other than AWP.

Nothing herein shall limit Caremark’s rights and abilities to establish additional networks at reimbursement terms as determined by Caremark.

6.04 Maximum Allowable Cost

Maximum Allowable Cost is a commonly used tool to control drug costs by establishing a fair but competitive unit price generally at a product level, regardless of supplier. MAC pricing incentivizes pharmacies to buy generic products as cheaply as possible, including volume discounts, in order to keep overall prices down for patients and health plans. Caremark does not have visibility to individual pharmacy arrangement with wholesalers; however, it is generally known in the industry that pharmacies do receive purchase discounts and rebates. It is not possible for Caremark to know what every pharmacy pays for every drug; however, Caremark may utilize aggregate information from wholesalers and third-party sources in order to establish MAC prices and, because MAC prices are reviewed continuously and updated frequently, our MAC prices reflect our best understanding of the marketplace pricing and product availability.

Caremark determines Maximum Allowable Cost generally at a product level for generic and multi-source brand products. This determination includes a review of marketplace dynamics, product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), MAC lists published by CMS, National Drug Acquisition Cost (NADAC) published by CMS, Predictive Acquisition Cost (PAC) developed by Glass Box Analytics, and if available, wholesalers and retail pharmacies. Caremark may update its MAC pricing methodology and/or use alternative pricing sources, at its discretion. MAC prices are subject to change, which can occur at least on a weekly basis and are based on marketplace trends and dynamics, and price fluctuations. MAC price lists are Caremark confidential and proprietary information.

For MAC paid claim appeals and as in accordance with Law, as applicable, Provider may appeal the MAC price paid by Caremark at a product level. Submission of a paid claim by Provider is required for this process. Provider must notify Caremark within the period required by applicable Law, and provide all of the following information: date of fill, prescription number, Provider name, Pharmacy NCPDP/NABP number, chain/affiliation code, phone number, email address, and RXBIN. Chain and Pharmacy Services Administration Organization (PSAO) pharmacies will submit MAC paid claim appeals through their respective chain or PSAO headquarters, which will then submit appropriate data to Caremark. Independent pharmacies (those which are not affiliated with a PSAO for contracting purposes) will submit MAC paid claim appeals using the Caremark Pharmacy Portal at www.rxservices.cvscaremark.com.

Provider may access the Caremark Pharmacy Portal to obtain current MAC prices and upcoming MAC prices based on Caremark’s MAC price update schedule, including for Medicare Part D plans. To locate current or upcoming MAC price information, utilize the “MAC Price Look Up” feature of the Pharmacy Portal available through a secure website: www.rxservices.cvscaremark.com. Providers can also request a MAC list by clicking on the “Pharmacists & Medical Professionals” link located at caremark.com and submitting a Pharmacy MAC List Request form to MACPRICE@cvscaremark.com.
6.05 Eligible Person Fees and Amounts

Unless otherwise authorized by Caremark in writing, Provider must collect at the point of service from Eligible Persons any administrative, transaction, access or other types of such fees or amounts, when applicable. The total amount to collect from the Eligible Person for providing Pharmacy Services, including any such fee or amount, will be communicated through the claims adjudication system and may be debited from Provider’s claims payment account. Refer to section 3.03.01 Collection of Patient Pay Amounts of the Provider Manual.

6.06 Claims Payment and Other Fees

6.06.01 Remittance Advises

Provider will receive a remittance advice for claim transactions within a payment cycle. Remittance reports may be distributed by mail, posted on one of the Caremark websites, or be available by other electronic means. Caremark payments to Provider may reflect adjustments for claims reversals, resubmissions or amounts owed by Provider to a Plan Sponsor under a provider agreement between Provider and a Plan Sponsor.

If Provider or authorized agent of Provider requires additional remittance reports, the following service fees apply:

<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>MINIMUM SERVICE FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper remittance reprint</td>
<td>$150/NPI/cycle</td>
</tr>
<tr>
<td>Internet, network data mover (NDM), data recreate, etc.</td>
<td>$500/item/NPI/cycle</td>
</tr>
<tr>
<td>Research fee associated with no change in reimbursement</td>
<td>$150/hour</td>
</tr>
<tr>
<td>Documentation request/research</td>
<td>$150/hour</td>
</tr>
<tr>
<td>Check trace/stop payment</td>
<td>$150/check</td>
</tr>
<tr>
<td>EFT Bank Account change</td>
<td>$150/NPI</td>
</tr>
<tr>
<td>835 Vendor change</td>
<td>$150/NPI</td>
</tr>
<tr>
<td>Provider claim adjustment request</td>
<td>$10/claim</td>
</tr>
</tbody>
</table>

If Provider receives remittance reports electronically, Provider must adhere to HIPAA regulations which mandate ASCX12N 835 and updates as required. Providers with questions regarding the testing, creation and receipt of the 835 data file should contact Caremark at the following address:

Caremark
Attn: Finance MC019
9501 East Shea Boulevard
Scottsdale, AZ 85260

All adjudicated claims detailed in a remittance advice are paid to Provider at one hundred percent (100%) of the reimbursement rate as in accordance with the Provider Agreement, pending audit by Caremark. All claims are subject to completion of audit. Prior to reimbursement, Caremark reserves the right to require additional documentation by Provider to validate a claim(s), including but not limited to, submission of medical records and Eligible Persons attestations.

6.06.02 Disputed Claims

Provider is required to review remittance advices received from Caremark to verify their accuracy. Notwithstanding any provision in the Provider Agreement, if Provider disputes a claim due to failure to pay the contractual reimbursement amount, Provider must notify Caremark in writing within one hundred eighty (180) days from date of fill, or within a longer period required by applicable Law, listing details of the disputed claim payment. Provider’s notification of a disputed claim must include the date of fill, prescription number, Eligible Person ID number and Provider NPI or NCPDP. Provider should include a copy of the remittance advice, if possible, and must provide the specific reason for the dispute. If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle, except for any overpayments made to Provider. Notifications may be mailed to:
Caremark
Attn: Network Services, MC023
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark may charge a research fee of $150/hour for any request in which Provider was accurately reimbursed. Caremark is not obligated to reimburse Provider for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim.

Refer to section 6.04 Maximum Allowable Cost of the Provider Manual for information regarding MAC appeals.

6.06.03 Claims Adjustment
Notwithstanding any provision in the Provider Agreement, if Provider requests an adjustment to a claim (e.g., to correct claims information submitted by Provider), Provider must notify Caremark in writing within one hundred eighty (180) days from date of fill, or within a longer period required by applicable Law. If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle. Claims adjustment requests must list the date of fill, prescription number, Eligible Person ID number, Provider NPI or NCPDP, Refill Code and TCN ID, the specific reason for the claim adjustment requested, and the information necessary to make the requested adjustment. To request a copy of the Claims Adjustment template, or for questions regarding data submission, contact the Pharmacy Help Desk. Claims adjustment requests may be mailed to:

Caremark
Attn: Adjustment Services, Pharmacy Corrections, NBT-4
9501 East Shea Boulevard
Scottsdale, AZ 85260

Providers may be required to submit claim adjustment requests electronically.

6.07 Recoupment and Adjustments
Caremark is not obligated to reimburse Provider for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider. Refer to section 8. Professional Audits of the Provider Manual for additional information on audits. Provider agrees and acknowledges that Caremark may, to the fullest extent allowed by law, recoup, charge back, offset, withhold or otherwise adjust payments due to Provider or any affiliate of Provider for claims improperly submitted by Provider or paid by Caremark.

6.08 Workers’ Compensation
Notwithstanding anything to the contrary, Caremark may utilize non-Medicare Part D networks for workers’ compensation claims. To the extent Caremark utilizes a non-Medicare Part D network for workers’ compensation claims and Provider participates in such network, the reimbursement for such workers’ compensation claim shall be as reflected in the applicable non-Medicare Part D network addendum (to the extent such network addendum does not conflict with the claims adjudication system) and the following additional terms will apply:

- Section 4.3 or Schedule A, whichever is applicable, of the Provider Agreement, is amended to add “(vi) the reimbursement amount prescribed by a state law for workers’ compensation (unless otherwise permitted by such state law), if applicable for workers’ compensation claims reimbursement.”
- Caremark may utilize a third-party vendor for certain portions of Caremark’s network services, including but not limited to, claims processing and pharmacy payments for workers’ compensation claims.

6.09 Provider Suspension
Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claims adjudication suspension) of Provider if required by applicable Law, or if Caremark has reason to believe Provider has engaged in, or is engaging in, any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider’s ability to fulfill the requirements of the Provider Agreement; (4) is a breach of the Provider Agreement; (5) alters the dispensing patterns of the Provider sufficiently to indicate potential
fraud, waste or abuse; or (6) constitutes potential fraud, waste, or abuse. Caremark’s ultimate remedies under this section include immediate termination of the Provider Agreement.

If Caremark is unable to reach Provider through any method provided during the enrollment or credentialing process (e.g., mail, telephone, fax, etc.), Caremark reserves the right to immediately suspend Provider. Caremark may elect to perform re-credentialing and/or audit, and may leave the suspension in place until such time as these processes are complete.

6.10 Directories
Caremark and Plan Sponsors may list Provider in directories and databases for distribution to, and use by, Eligible Persons, Plan Sponsors and others as Caremark or a Plan Sponsor determines are necessary. Additionally, Caremark may display Provider, if applicable, in preferred provider performance initiatives in paper, web-based directories, or Plan Sponsor reporting. Refer to section 14.01 Advertising and Trademarks of the Provider Manual.

CVS Caremark has a requirement to maintain accurate directories of Dispensing Pharmacies so that patients can quickly find pharmacies to fill their prescriptions. Therefore, Providers that have no dispensing activity of Covered Items for a period of time may be immediately removed from the network as determined at CVS Caremark’s sole discretion.
7. Compliance Reviews

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

In order to determine Provider’s compliance with the terms of the Provider Agreement and applicable Law, Caremark has the right to examine Provider records (and obtain a copy as necessary) and pharmacy practices as Caremark reasonably determines are necessary. Provider must comply with such examination within the timeframe indicated by Caremark on the notice of the examination and without charge to Caremark. Caremark conducts examinations in accordance with the Provider Agreement and applicable Law and Caremark may, in accordance with applicable Law, refer Provider’s non-compliance to local/state/federal investigative and law enforcement agencies as appropriate.

Submission of false or misleading records and documentation may result in chargeback for all claims reviewed and any other remedies available to Caremark, including but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies. If clarification of documentation is requested by Caremark, Provider is required to submit unaltered original documentation.

Examples of Compliance Reviews include:

- Concurrent/Daily Review
- Medicare/Medicaid Review
- Telephone or Facsimile Inquiries
- Provider Tax determinations and legal basis for calculation of such Provider Tax

To the extent consistent with applicable Law, non-compliance of the Agreement includes, but is not limited to,

1. Submitting incorrect data in the claims submission;
2. Failure to provide documents requested by Caremark pursuant to the Agreement;
3. Refusing to accept an Identification Card for an Eligible Person;
4. Refusing to service an Eligible Person because of the reimbursement rate;
5. Failing to submit a claim for a Covered Item for an Eligible Person;
6. Disclosing Confidential Caremark Information;
7. Submitting the incorrect applicable DAW code;
8. Submitting an inaccurate U&C;
9. Non-adherence to section 3.03.01 Collection of Patient Pay Amounts of the Provider Manual;
10. Not dispensing an emergency supply of a Covered Item to an Eligible Person as required by applicable Law;

Provider must not separate cash and third-party prescription business or own, operate, or affiliate with a non-participating Provider to manipulate claims pricing for inappropriate financial gain.

7.01 Non-Compliance Fees

Caremark may find it necessary to perform reviews on claims prior to payment. Provider agrees that Caremark may review submitted claims and charge a reasonable amount to the Provider consistent with the resources required to perform the review. These reviews may be performed on all claims submitted by the Provider and may include, but not be limited to, consulting with the Prescriber or patient; review of copayment collection evidence, original prescription, prior authorization documentation, etc.; and other reviews to confirm compliance with the Provider Manual and Applicable Law.
Caremark may assess against Provider a $375 administration fee for an initial occurrence of non-compliance or for each non-compliant submitted claim, increasing in $375 increments for subsequent non-compliant events (e.g., $375, $750, $1,125). Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for charges for non-compliance pursuant to the Provider Agreement or any Third-Party Agreement, or claims submitted in breach of the Agreement.

Provider is liable for all fees, interest, penalties, damages, withholds, judgments, financial obligations, or other charges imposed upon Caremark as a result in whole or in part from Provider’s non-compliance or omissions of any act or responsibility assumed by Provider under the Agreement.

Caremark’s rights under this section survive the termination of the Provider Agreement.

### 7.02 Additional Information Regarding Compliance Reviews

1. Provider must be reachable by Caremark based on the contact information (as updated) that Provider specified to Caremark as part of enrollment or credentialing. It is essential that Provider keep contact information up to date to ensure reminders and other important communications are received. Refer to section **2.06 Notification to Caremark** of the Provider Manual.

2. Documents and records subject to review include, but are not limited to the following:
   a. Prescription hard copies – scanned images must include both the front and back images of the original and the original must be retained and retrieved if requested
   b. Signature logs
   c. Delivery logs with tracking information for mailed or home/business delivered prescriptions
   d. Prescription label and dispensing label
   e. Compound Record and subformulations, which must include at minimum, NDCs of items used, lot numbers, expiration dates, compounding instruction, final compounded dosage form, signature of verifying pharmacist and certificate of analysis. Provider must keep Compound Records for the same time period as required for prescription hard copies. Refer to section **4. Claims Submission** of the Provider Manual
   f. Evidence of copay collection including proof of financial transaction. Refer to section **3. Pharmacy Services and Standards** of the Provider Manual
   g. Methodology used to determine appropriate beyond-use date

3. For claim submission requirements refer to section **4. Claims Submission** of the Provider Manual.

4. For specific drug submission requirements, refer to **Appendix D – Drug Submission Requirements** of the Provider Manual. Audit Tip Communications may be sent to Providers periodically to advise of drug submission requirement updates.

5. For additional claim processing information, refer to the Caremark Payer Sheets at [www.caremark.com/pharminfo](http://www.caremark.com/pharminfo).

6. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).
8. Professional Audits

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

As a service to its Plan Sponsors and Eligible Persons, and to educate Providers in complying with the Provider Agreement, Caremark engages in an on-going audit program. The audit program also serves to protect against fraud, waste, and abuse. As part of this program, Caremark may conduct reviews and audits of claims prior to payment to ensure compliance with the Provider Agreement. Caremark may also audit the claim post-payment. The positive adjudication of any claim does not limit or preclude Caremark’s ability to review or otherwise audit or recoup that claim.

8.01 Types of Audits

Audits may be conducted in the form of an on-site audit, investigational audit, or desktop audit. There are other compliance reviews that Caremark may conduct as described in section 7. Compliance Reviews of the Provider Manual.

8.01.01 On-site Audits

Caremark performs routine on-site audits. Caremark as a routine business practice may notify Provider two (2) weeks prior to a scheduled audit date or as required by applicable Law. For an on-site audit, auditors will generally review specific documents and records related to claims paid to Provider by Caremark during the previous twenty-four (24) months, unless otherwise required by applicable Law.

8.01.02 Investigational Audits

For an investigational audit, Provider is contacted via telephone, facsimile, or through the mail, and asked to provide specific documents and records related to claims paid to Provider or Eligible Person by Caremark during a specified period. Documentation may include, but not be limited to, prescription hard copies, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications.

8.01.03 Desktop Audits

For a desktop audit, Provider is contacted via telephone, facsimile, or through the mail to satisfy records and documentation requirements for limited reviews (e.g., MEDIC requests, CMS audits, Plan Sponsor audit inquiries, and compliance audits). Records and documentation requested must be provided in a timely manner not to exceed ten (10) days or according to applicable Law. Failure to submit all the required documentation by the due date may result in claim reversal, non-compliance fees, submission of a Corrective Action Plan (CAP), or potential termination from the provider network.

8.01.04 Audits by Government Agencies

Provider agrees that state and federal government agencies and their respective duly authorized representatives or designees, including but not limited to, the Department of Health and Human Services and CMS (collectively “Government Auditors”) have the right, for the period allowed by Law, to review, audit, examine, and reproduce Provider’s books, records, prescription records, and other documentation, to the extent such Government Agency Audit is required by Law or under the asserted authority of the Government Auditor (“Government Agency Audit”), and Provider will cooperate in good faith with such Government Agency Audit. To the extent the Government Auditor requests either of Caremark’s or Plan Sponsor’s Provider books, records, prescription records, and other documentation as part of the Government Agency Audit, Provider agrees that it will provide such Provider’s books, records, prescription records, and other documentation to Caremark within the timeframe as notified by Caremark based upon the Government Agency Audit, and agrees that Caremark has the right to produce to such Provider’s books, records, prescription records, and other documentation in Caremark’s possession.

8.02 Professional Audits Rights

During the term of the Provider Agreement and for two (2) years following the termination of the Provider Agreement (or such time permitted under applicable Law), Caremark has the right to audit Provider’s records and documents, facility and practices as Caremark reasonably determines are necessary to evaluate Provider’s compliance with the
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Provider Agreement and applicable Law. Caremark’s audit may cover any claim submitted by Provider or Eligible Person to Caremark or Plan Sponsor for adjudication (regardless of the method of submission), claims for Covered Items, and U&C submissions. To the extent allowed by Law, if there is a conflict between the Provider Manual and applicable Law with respect to an audit of Provider, the audit is subject to the stricter provision.

Nothing in this Professional Audits section prohibits Caremark from conducting an audit of Provider that does not follow the established audit procedures set forth in this Professional Audits section to determine Provider’s compliance with the terms of the Agreement, but in all cases compliant with applicable Law. Refer to section 7. Compliance Reviews of the Provider Manual for other rights.

Unless unusual circumstances exist, Caremark will schedule an audit in advance and work with Provider to accommodate reasonable schedule change requests made prior to the audit date to a mutually agreeable time. Notice of an audit may be communicated to Provider via facsimile, telephone, or mail.

Throughout the audit process:

- Provider is expected to be an active participant to ensure audit findings are accurate. Provider may designate an employee to facilitate the audit on behalf of Provider.
- Provider must provide the Caremark auditor with a clutter-free work area that does not disrupt the provision of Pharmacy Services, but with ease of access to records and documents required for the audit.
- Provider must maintain proper staffing during the audit to ensure that Provider is reasonably available for questions and the retrieval of records. If possible and requested by Provider, the Caremark auditor will wait a reasonable amount of time (10-15 minutes) while Provider locates any missing records and documents not found during the course of the audit.
- Provider must provide access to a Plan Sponsor (and its representatives or agents) to examine, audit, and copy Provider records and documents pursuant to its authority under contract with Caremark or by applicable Law.

Provider authorizes Caremark to release Provider’s information, records, and documents to governmental authorities (and their agents), Plan Sponsors, and wholesalers upon request. Refer to section 8.01.04 Audits by Government Agencies of the Provider Manual. Caremark reserves its rights under section 14.03 Confidentiality of the Provider Manual.

If the Caremark auditor is denied access to Provider’s records, documents, or facility, Provider is deemed non-compliant. Caremark has the right to recoup one hundred percent (100%) of the amount for the claims in question, with such amount becoming immediately due and owing to Caremark. Caremark has the right to offset the amounts due against any amount due to Provider. Caremark may also exercise all remedies available to it, including but not limited to, payment suspension (in accordance with the terms of the Provider Manual) until the audit is completed or termination of the Agreement. In addition to other remedies, Caremark reserves the right to charge Provider for the costs of travel and expenses associated with the audit and additional resources needed to address audit non-compliance.

Caremark audits do not employ extrapolation unless required under applicable Law.

Provider must notify Caremark in the event of a change in the pharmacy’s physical location prior to the change. Refer to section 2.06 Notification to Caremark of the Provider Manual.

8.03 Documents and Records Production Related to Audits

Provider must provide Caremark with all requested documents and records as Caremark reasonably determines are necessary to evaluate Provider’s compliance with the terms of the Provider Agreement and applicable Law, and Provider must fully comply with such requests, including the delivery of all requested documents and records to Caremark by the specified due date and without charge to Caremark; if Provider fails to provide requested documents and records, the entire amount of the paid claim for which documents and records were not provided are due and owing. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date.

Submission of false or misleading records and documentation may result in chargeback for all claims audited and any other remedies available to Caremark, including but not limited to, termination of the Agreement and referral to local/state/federal investigative and law enforcement agencies. If clarification of documentation is requested by Caremark, Provider is required to submit unaltered original documentation.

Documents and records must be readily retrievable at the Dispensing Pharmacy.

Caremark reserves the right to not consider Provider actions (and documentation of such actions) that take place
after Provider is notified of an audit as a demonstration of compliance with the Agreement. Refer also to section 3.03.01 Collection of Patient Pay Amounts of the Provider Manual.

Provider’s failure to comply with document and records requests as required under the Agreement is a breach of the Agreement and is subject to remedies available to Caremark including termination of the Agreement.

8.04 Documents and Records Subject to Audit

Documents and records subject to audit include, but are not limited to, the following:

- Prescription hard copies - Scanned images must include both the front and back images of the prescription hard copy; and the prescription hard copy must be retained and retrieved if requested. Prescription hard copies or scanned images of prescription hard copies must be legible by Caremark
- Signature logs
- Delivery logs with tracking information for mailed or home/business delivered prescriptions
- Daily prescription logs
- Wholesaler, manufacturer and distributor invoices (with NDC, drug names, quantity, package size, etc.)
- Transaction Statement, Transaction History, and Transaction Information and Documentation as defined in section 8.05 Supply of Covered Items; Purchase Invoices of the Provider Manual
- Refill information
- Prescriber information
- Patient profiles/Prescriber orders
- Records to validate U&C
- Prescription label and dispensing label
- Provider system report of Pharmacy Services reversed, returned to stock, or not dispensed with confirmation of reversal of the claim submission
- Recorded diagnosis on prescription hard copy or maintained in the computer system for all Medicare Part B Pharmacy Services dispensed under a Medicare Part D plan
- Record of Eligible Person location (e.g., skilled nursing facility, assisted living facility) when claim is dispensed
- Records of transfer/sale between providers of drugs and devices used for Pharmacy Services
- Records of prescription transfers, including evidence of Eligible Person’s express permission to Provider to transfer his or her prescription to another pharmacy
- Medication pricing brochures for cash customers (e.g., paper pamphlet, promotional signage, internet listing)
- Patient consent and administration record of vaccine claims (combination vaccine/administration)
- Evidence of copay collection including proof of financial transaction [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash]. If the Patient Pay Amount is reduced due to a coordination of benefits, Provider must provide evidence of the claim adjudication to the secondary payer
- Documents pertaining to individualized determination of financial need or exhaustion of reasonable Patient Pay Amount collection efforts. Refer to section 3.03.01 Collection of Patient Pay Amounts of the Provider Manual
- Proof of completion of annual Medicare Part D FWA training and General Compliance Training (GCT)
- Verification that Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section 2.11 Federal Health Care Programs Participation Exclusion: Pharmacy of the Provider Manual
- Prescription record documentation for Medicare Part D Enrollees with diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage [e.g., Hospice, Part B vs. Part D, ESRD]
- Signed Prescriber or patient attestation legitimizing the dispensing of the prescription if a prescription hard copy, medication order, patient signature log or patient delivery log is not retrievable. Prescriber attestations must be written on the Prescriber’s business letterhead or on the Prescriber’s prescription. Attestations provided by the Prescriber must clearly indicate the source of the attestation (i.e., clearly visible fax signature that the attestation originated from the Prescriber’s office or Prescriber’s stamp on the attestation)
• All records acquired in the purchase of a pharmacy or in the purchase of pharmacy files
• Documentation substantiating transmission of submission clarification codes (SCC) or override codes
• Evidence of verification of legitimate Prescriber/patient relationship if Provider knows or reasonably should know that there is not a legitimate Prescriber/patient relationship
• Collaborative practice agreement(s)
• Credit Card Merchant Account Report including evidence of settlement and payment through bank records
• Policies and procedures related to all Provider operations, including but not limited to, collection of Patient Pay Amounts and inventory controls
• Documents to evidence that Provider is compliant with their own policies and procedures and/or corrective action plan
• Any document deemed necessary by Caremark to determine Network Provider’s compliance with any terms and conditions set forth within this Provider Manual
• Refer to section 7.02 Additional Information Regarding Compliance Reviews of the Provider Manual for required Multi-Ingredient Compound Documents

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 C.F.R. 164.502 and 45 C.F.R. 154.501). Provider further acknowledges that in order to receive payment from Caremark, Provider is required to allow Caremark to conduct audits of its prescription and other pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws. Additionally, Provider recognizes that Caremark audit staff may be exposed to or otherwise become aware of certain confidential, protected, and individually identifiable health information of patients who are not Eligible Persons during the course of the audit review, and that such disclosures by Provider to Caremark are incidental to the payment disclosures and are therefore permitted by HIPAA under 45 C.F.R. 164.502(a)(iii) provided that reasonable safeguards are implemented by Provider to limit such incidental disclosures. Caremark will maintain confidentiality of this information and will not disclose, publish or otherwise reveal any of this confidential information except as necessary to conduct its audit pursuant to applicable Law.

8.05 Supply of Covered Items; Purchase Invoices

All Covered Items used by Provider to fill prescriptions or otherwise meet requests of Eligible Persons must be sourced from an Authorized Trading Partner [which includes manufacturers, distributors, wholesalers, and other pharmacies] as defined under the Drug Supply Chain Security Act 21 U.S.C.A § 360eee (“DSCSA”) that is subject to regulatory oversight and duly licensed under all applicable Law, including but not limited to, the Food and Drug Administration, Drug Enforcement Administration and state Boards of Pharmacy. For those Covered Items that are regulated by the DSCSA and any regulations promulgated under the DSCSA, Provider must maintain the Transaction Statement, Transaction History, and Transaction Information that it receives from the Authorized Trading Partner as set forth in this section.

For those Covered Items for which a Transaction Statement, Transaction History and Transaction Information are not required by the DSCSA, Provider must maintain records of the exact quantities purchased, name of the Authorized Trading Partner, Covered Item name(s), NDC, date(s) of purchase, and proof of payment [e.g. copies of credit card receipts, canceled checks (front AND back)] (collectively “Documentation”). Unless permitted by applicable Law, Provider must not use foreign-sourced Covered Items, samples, returned, recalled, expired, or otherwise “suspect”, as defined below, Covered Items to dispense to or otherwise provide for Eligible Persons under the Provider Agreement. For diabetic testing supplies, Provider must use diabetic products that have been sourced either from within the manufacturer’s authorized distribution channel or purchased directly from the manufacturer.

It is the sole responsibility of Provider to ensure that all wholesalers, manufacturers, distributors, or other pharmacies that Provider utilizes to source Provider’s purchases of Covered Items are Authorized Trading Partners, or in the case of diabetic test strips, sourced from within the manufacturer’s authorized distribution network. As a means to identify the authorized distribution network, Provider shall search the manufacturer’s website and print the listing of authorized distributors from the manufacturer’s website and maintain this document in Provider’s records to demonstrate compliance. Provider must check the authorized manufacturer’s website (no less than annually) to ensure that it is utilizing the most current information in order to protect patient safety.

Provider’s receipt of Covered Items when Provider knows, or reasonably should have known, that the Covered Item
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8.05.01 Invoice Documents and Records Maintenance
Provider must maintain any Transaction Statement, Transaction History, and Transaction Information provided to Provider pursuant to the DSCSA and any regulations promulgated under the DSCSA for the period required by applicable Law and any Documentation during the term of the Agreement and for two (2) years after the termination of the Agreement.

8.06 Medicare Part D Requirements
Provider must provide documentation to demonstrate compliance with all Medicare Part D requirements (as stated in the Provider Manual, Caremark Medicare Part D Addenda, CMS guidance or under applicable Law) including, but not limited to:

- Long-term Care billing
- Accurate use of Patient Residence and Pharmacy Service Type values
- Compliance with “CMS-10147 Medicare Prescription Drug Coverage and Your Rights” pharmacy notification
- Documentation to establish coverage determinations (e.g., Hospice, Part B vs. Part D, ESRD)
- That Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section 2.11 Federal Health Care Programs Participation Exclusion: Pharmacy of the Provider Manual to confirm that no Prescriber transmitted on a Medicare Part D claim is on any exclusion list
- Documentation or information requested which relates to a Medicare Part D claim dispensed by Provider but reimbursed directly to other parties, including the Part D Enrollee
- Documentation substantiating any submission clarification codes (SCC) or override codes transmitted on a Medicare Part D claim
- Documentation submitted must comply with guidance set forth by CMS, or any other applicable regulatory body or its designated auditor

If a copy of a prescription or signature log is not retrievable after sufficient effort, Provider must obtain either Prescriber or Eligible Person attestations.

8.07 On-Site and Investigational Audit Resolution – Appeals Process
As part of an audit, Caremark may identify claim discrepancies. If Caremark identifies claim discrepancies, Caremark will send Provider an initial discrepancy report along with Documentation Guidelines (refer to Appendix I of the Provider Manual) that show how Provider may address an initial discrepancy and validate the audited claim through a written appeals process.
If Provider chooses to appeal the initial discrepancies, Provider must respond to Caremark in writing within thirty (30) days, or other timeframe required by applicable Law, with supporting documentation for the discrepant claim in accordance with the Documentation Guidelines or the Provider Manual. Documentation must be transmitted to Caremark via certified mail, fax, Federal Express, United Parcel Service, or any other certified carrier (with delivery confirmation), and must be received by the due date specified by Caremark. Provider may contact the Pharmacy Performance department at 1-866-488-4709 prior to the documentation due date to request an extension of the documentation due date. Caremark reserves the right to deny a request for extension of a documentation due date that is made before the original specified due date. Late documentation will not be accepted.

Upon review of Provider’s appeal documentation, or at the end of the thirty (30) day appeal period if Provider has not submitted appeal documentation, Caremark will issue a final audit report. Discrepant claims that are not documented and validated in accordance with the Documentation Guidelines or the Provider Manual are detailed in the final discrepancy report and are due and owing to Caremark as of the expiration of the thirty (30) day appeal period, or other timeframe required by applicable Law; however, Caremark has the right to offset, if consistent with applicable Law, against amounts owed to Provider, before the expiration of the thirty (30) day period, or other time period required by Law, for any discrepant claims as allowed for under section 6.09 Provider Suspension of the Provider Manual. Audit discrepancies are detailed in a final audit discrepancy report.

Any documentation submitted after the documentation due date (i.e., for the initial discrepancy report) or after a final audit discrepancy report is issued may be considered by Caremark as part of Caremark’s evaluation of the remedies to be taken by Caremark to address the audit findings, but will not impact the final chargeback amount owed to Caremark.

Refer to section 15.09 Arbitration of the Provider Manual for the dispute resolution process once the final audit discrepancy report is complete.

If the final audit chargeback exceeds $10,000, Provider must reimburse Caremark twenty percent (20%) of the total final audit chargeback for the cost of the audit, where consistent with applicable Law.

Provider must notify Caremark of Provider’s appeal of an initial discrepancy report, in writing to:

Caremark – Audit Manager
Attn: Pharmacy Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for audited discrepant claims, audit-related costs pursuant to the Provider Agreement or any Third-Party Agreement, claims submitted in breach of the Agreement, or any audit conducted by a third-party auditor on behalf of a Plan Sponsor. If the Provider fails to satisfy amounts owed related to an audit finding, certain remedies may apply, including termination of the Provider Agreement and any other available remedies.

When Caremark collects from Provider amounts due as a result of audit discrepancies, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or Plan Sponsor in relation to such adjustment or chargeback.

Once Provider is on notice of an on-site or investigative audit, Provider must not during the audit process adjust or reverse claims that are the subject of the audit as Caremark will perform appropriate adjustments and reversals at the conclusion of the audit process.

Caremark may report its audit findings to Plan Sponsors and local/state/federal investigative and law enforcement agencies (and their agents).

8.07.01 Pharmacy Membership Review Committee
Caremark’s Pharmacy Membership Review Committee (PMRC) is a committee responsible for reviewing final audit cases to determine remedial actions that the PMRC determines are appropriate to address the audit findings. The PMRC meets regularly and is comprised of Caremark employees representing multiple departments and industry experiences.

8.08 Corrective Action Plan
A corrective action required (CAR) notice may be sent to Provider requiring Provider to submit a corrective action plan (CAP) concerning issues such as audit findings, dispensing errors, failure to respond to audit requests or as
may be required by applicable Law. Provider must respond to any request for information and action in a CAR notice. Provider’s response must be submitted by the date provided on the CAR and must include a CAP. Provider’s CAP must include applicable documentation and policies and procedures as specified in the CAR notice to support Provider’s CAP. As part of the CAP process, Provider may be assessed a per claim review fee for oversight claim activity during the CAP period. If Provider fails to fully respond to a CAR notice or any other request for information and action as part of the CAR/CAP process, or fails to follow the CAP, Caremark reserves the right to exercise its termination rights under the Provider Agreement, along with other available remedies.

8.09 Potentially Fraudulent Activity

If Provider suspects that potentially fraudulent prescriptions are being presented or that other improprieties regarding claims are occurring, Provider must notify Caremark by telephone at 1-877-841-1851 or by written correspondence at:

Caremark
Attn: Network Performance, MC020
9501 East Shea Boulevard
Scottsdale, AZ 85260

Provide the Eligible Person’s name and identification number, the Prescriber name and identification number, a detailed description of the suspected fraudulent activity and any related supporting documentation.

Examples of potentially fraudulent activity that warrant notification to Caremark may include, but not be limited to:

- Eligible Person presenting a forged or altered prescription
- Eligible Person presenting a prescription not written by the Prescriber identified
- Eligible Person calling in his or her own prescription
- Eligible Person presenting a prescription indicating a medication which is not consistent with the practice or specialty of the Prescriber
- Eligible Person presenting a prescription for an ineligible person, or fictitious family member

Provider may also consider notifying the Drug Enforcement Administration (DEA) or other related regulatory agencies.
9. Medicaid

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

To the extent Provider provides Pharmacy Services to a Medicaid Eligible Person and without limiting any other provision in the Agreement (including the Provider Manual), Provider must, at minimum, comply with the following terms:

9.01 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicaid Eligible Person is made, in whole or in part, from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable state laws including minimum standards of pharmacy practice. Refer to the Federal and State Laws and Regulations section of the Provider Manual (located in the Pharmacy Portal, login required, at www.rxservices.cvs caremark.com), including state-specific addenda. Provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. [42 C.F.R. 438.230(c)(2)]. Provider acknowledges that Provider’s ability to provide Pharmacy Services under the Agreement for Medicaid Eligible Persons may be revoked if it is determined that Provider has not performed satisfactorily [42 C.F.R. 438.230(c)(1)(iii)].

9.02 Enrollment with State Medicaid

Pursuant to 42 C.F.R. 438.602(b), Provider shall ensure that it is enrolled with each state Medicaid for which Provider provides Pharmacy Services under the Agreement. Provider agrees that if it is not enrolled with the applicable state Medicaid program, it may not provide Pharmacy Services under the Agreement for that state Medicaid program’s enrollees.

9.03 Medicaid Credentialing and Quality Management

Provider shall comply with Caremark’s credentialing and quality management requirements. Provider must provide Caremark with documentation and other information that is required to comply with “Disclosure of Information by Providers and Fiscal Agents” (42 C.F.R. Part 455, Subparts B, E); otherwise, Provider may be subject to termination or other available remedies. Refer to section 2. Credentialing and Quality Management of the Provider Manual for additional information.

Provider must allow CMS, its agents, its designated contractors (e.g., recovery audit contractors), or the applicable state Medicaid agency to conduct unannounced on-site inspections of Provider’s location(s). 42 C.F.R. § 455.432.

9.04 Fraud, Waste and Abuse Compliance Program

Provider shall maintain a compliance program in accordance with 42 C.F.R. 438.608 to detect fraud, waste, and abuse.

9.05 Inspection and Audit of Records and Access to Facilities

Pursuant to 42 C.F.R. 438.3(h), Provider shall allow a state Medicaid program, CMS, the DHSS Office of the Inspector General, the Comptroller General, and their designees, to, at any time, inspect and audit any records or documents of Provider, and inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for ten (10) years from the final date of the Agreement or from the date of completion of any audit, whichever is later. See also 42 C.F.R. 438.230(c)(3).

9.06 Claims Submission Requirements for Medicaid

Additional Plan Sponsor-specific information, such as claims submission requirements for 340B drugs, may apply as specified in notices to Provider or in the Caremark Payer Sheets. Refer to the Caremark Payer Sheets at www.caremark.com/pharminfo.

9.07 Medicaid Coordination of Benefits

Medicaid is typically the payer of last resort, which pays after any other applicable primary programs have
been billed. Prior to dispensing a Covered Item to an Eligible Person, Provider must inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person’s benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider must submit its claim to the appropriate payer as required by and in accordance with any COB requirements, and must engage in appropriate COB activities to the extent required by Caremark, or applicable by Law.

Refer to section 4.10 Coordination of Benefits of the Provider Manual. For complete technical information on COB, refer to the Payer Specification Sheets located at www.caremark.com/pharminfo.

9.08 Prior Authorization

Where permitted by applicable state Law and the Plan Sponsor, Provider is authorized to dispense a limited number of days supply of medically necessary Covered Items if the Prescriber is unavailable to process a prior authorization request within a reasonable time period. Plan Sponsor-specific processes and contact information may apply as indicated in Caremark Documents.

Unless specifically instructed otherwise by Caremark or the Plan Sponsor, Provider is not authorized to enter overrides for an emergency fill without contacting the Pharmacy Help Desk.

9.09 Denial of Services

Provider must not deny services to an Eligible Person on account of such individual’s inability to pay the Patient Pay Amount to the extent consistent with applicable Law.

9.10 Cultural Competency

Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. § 438.206(c)(2).

9.11 Home Delivery

A Medicaid beneficiary may not be charged for the expense or any portion of an expense as the result of a prescription medication being mailed, shipped or delivered, etc.

9.12 Directories

Provider shall provide Caremark with all information that may be needed in connection with Caremark’s initiatives to comply with 42 C.F.R. 438.10 concerning pharmacy directories.
10. Medicare Part D

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

10.01 Medicare Part D Network Standards

To the extent Provider provides Pharmacy Services to a Part D Enrollee, Provider must comply with the following terms contained in this Medicare Part D Network Standards section of the Provider Manual. Unless specifically indicated otherwise, these terms apply to all Providers who provide Pharmacy Services to a Part D Enrollee (including retail, home infusion, long-term care, and Indian Health Services/Tribal/Urban Providers). Provider acknowledges that CVS Caremark Part D Services, L.L.C. together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, “Caremark” for the purposes of this section) are responsible for providing Part D services on behalf of Part D Plan Sponsors. All capitalized terms used in this Medicare Part D Network Standards section will have the same meaning as in the applicable Addendum to the Caremark Provider Agreement: Terms of Participation in Medicare Part D, or the Glossary of Terms in the Provider Manual.

10.01.01 Network Participation

For any Part D plan year, and to ensure adequate access to network pharmacies for Part D Enrollees, Provider must provide Caremark with written notice by no later than March 31 of the prior calendar year if Provider will not be participating in a Medicare Part D network, including but not limited to, the retail, long-term care, and home infusion networks, for that plan year. For example, if Provider will not be participating in the Medicare Part D retail pharmacy network for the 2020 plan year, it must notify Caremark in writing by no later than March 31, 2019. If such timely written notice is not given, Provider must participate in such Medicare Part D network for the entire Part D plan year unless Provider terminates with cause its participation in accordance with the Provider Agreement.

The terms of this Network Participation section supersede and amend any inconsistent or contrary provision in the Provider Agreement, including section 15.05.02 Termination Without Cause of the Provider Manual, but will only apply to the extent that this section is consistent with a Part D Plan Sponsor requirement.

The deadlines set forth in section 6. Network Participation and Payment of the Provider Manual do not apply to Medicare Part D network solicitations to participate in a new Medicare Part D network for which the deadline for participation will be as stated in such Caremark written solicitation.

10.01.02 Compliance with Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Part D Enrollee is made, in whole or in part, from federal funds, and subjects Provider to laws, such as but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with minimum standards of pharmacy practice under applicable state Law. Refer to section 16. Federal and State Laws and Regulations of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Caremark Pharmacy Portal, refer to section 1.06 Pharmacy Portal of the Provider Manual.

10.01.03 Delegated Activity

Provider must obtain prior written approval from Caremark if Provider wishes to delegate any activity or responsibility related to its Pharmacy Services to a subcontractor. Upon Caremark’s written approval of such delegation, Provider must obtain written agreement from such subcontractor that the subcontractor will comply with all of the terms and conditions of the Provider Agreement (which includes the Provider Manual) applicable to Provider, including but not limited to, the requirement to comply with the contractual obligations specified for downstream entities in 42 C.F.R. 423.505(i)(2) and (i)(3) that relate to, among other things, retention of books and records, including prescription records, for at least ten (10) years or longer as specified in 42 C.F.R. 505(i)(2); and sections 2.11 Federal Health Care Programs Participation Exclusion: Pharmacy; 4. Claims Submission, and 8. Professional Audits of the Provider Manual. Provider’s written agreement with subcontractor must provide that the agreement and/or delegated activities may be revoked (or specify other remedies) in instances when CMS, Part D Plan Sponsor, or Caremark or any of Caremark’s subsidiaries or affiliates determines that the subcontractor has not performed satisfactorily. In the event that any subcontractor is terminated by CMS or Part D Plan Sponsor, Provider must immediately notify Caremark of such termination.
10.01.04 Offshore Subcontracting
If Provider or any of Provider’s subcontractors (or downstream subcontractors) receive, process, transfer, handle, store, or access Protected Health Information (PHI) of Part D Enrollees outside the United States or one of the United States Territories, Provider agrees to notify Caremark and to comply (and to require any downstream subcontractors to comply, as applicable) with the requirements specified in CMS memorandum of July 23, 2007, entitled “Sponsor Activities Performed Outside of the United States (Offshore Subcontracting).” Further, Provider agrees to submit to Caremark information to enable Caremark or Caremark’s Part D Plan Sponsors to provide the “Attestation Concerning the Use of Offshore Contractors” form contained in the July 23, 2007, CMS memorandum, which includes, but is not limited to, providing to Caremark information of Provider’s own or Provider’s offshore subcontractor operations, safeguards to protect PHI, and auditing to ensure protection of PHI.

10.01.05 Marketing
Provider must conduct marketing activity in a manner consistent with the Medicare regulation and guidelines, including the Medicare Communications and Marketing Guidelines. Provider must remain neutral when assisting Part D Enrollees with enrollment decisions in an objective assessment of his or her needs and potential options to meet those needs.

10.01.06 Fraud, Waste and Abuse Program
Provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Compliance Program Guidelines to prevent, detect and correct Fraud, Waste and Abuse (FWA). Provider also agrees to comply with Part D Plan Sponsor’s policies and procedures, and any corrective action plans imposed by Part D Plan Sponsors or Caremark related to the Part D Program. Provider must submit copies of Provider’s policies and procedures, and corrective actions related to Part D activities as requested by Caremark. Provider must cooperate fully with a Part D Plan Sponsor’s FWA investigative activities including providing copies of prescriptions, signature logs, and other requested documentation to support FWA investigations.

10.01.07 Information on CMS-10147 Pharmacy Notice

CMS-10147 - Medicare Prescription Drug Coverage and Your Rights

1. CMS requires that Caremark distribute the “Medicare Prescription Drug Coverage and Your Rights” form (Pharmacy Notice – CMS 10147) to Providers on an annual basis. This form is used to instruct Part D Enrollees to contact their Part D Plan to obtain a coverage determination (prior authorization) or ask for a formulary or tiering exception if the Part D Enrollee disagrees with Plan claim response information provided to the Pharmacy.

2. Pharmacies must provide the Part D Notice of Appeal Rights directly to Part D Enrollees any time the following reject(s) and related messaging occurs on a claim:

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>

3. This notice is provided in Appendix G of the Provider Manual in English and Spanish. This is a standard notice and Provider may not deviate from the content of the notice. Note that the OMB control number [APPROVED OMB #0938-0975] must be displayed in the upper right corner of the notice.

4. This document is distributed to Pharmacy annually by Caremark and is also posted at: www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html

5. Distributing this notice fulfills the requirements at 42 C.F.R. § 423.562(a)(3).

10.01.08 Performance Monitoring
Provider understands that Caremark and Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis. Provider must cooperate with Caremark and Part D Plan Sponsor as necessary to support Caremark and Part D Plan Sponsor monitoring strategies, including but not limited to, allowing Caremark and Part D Plan Sponsor to inspect, evaluate and audit Provider’s operations, documents and records.
10.02 General Information

10.02.01 Part D Reference Information for Pharmacists
Refer to the following website: www.cms.gov/Medicare/Medicare.html which contains helpful information on a variety of Medicare Part D topics for providers. CMS frequently updates this website, so check periodically for the latest information.

10.02.02 Medicare Part D Calls to the Pharmacy Help Desk
The Pharmacy Help Desk interactive voice response (IVR) system immediately routes Medicare Part D inquiries to appropriate information/pharmacy service representatives through an initial request/prompt to discover if Provider is calling on behalf of a Part D Enrollee or about a Medicare Part D Claim.

Provider will be routed to a specialized team prepared to handle and resolve Medicare Part D inquiries. If the Part D Enrollee does not have an ID card available, ask for an acknowledgement letter. If an acknowledgement letter is not available, call 1-800-MEDICARE (1-800-633-4227). Only if needed, Provider can submit an enhanced E1 transaction to determine the processing information.

The Pharmacy Help Desk numbers are provided below:

<table>
<thead>
<tr>
<th>Caremark System</th>
<th>RXBIN</th>
<th>Pharmacy Help Desk Number</th>
<th>Point-of-Service Assistance B vs D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy ADV</td>
<td>004336*</td>
<td>1-866-693-4620</td>
<td></td>
</tr>
<tr>
<td>Legacy PCS</td>
<td>610415*</td>
<td>1-800-345-5413</td>
<td></td>
</tr>
<tr>
<td>FEP</td>
<td>610239*</td>
<td>1-800-345-5413</td>
<td></td>
</tr>
<tr>
<td>Legacy CRK</td>
<td>610029*</td>
<td>1-800-421-2342</td>
<td></td>
</tr>
<tr>
<td>Caremark</td>
<td>610591</td>
<td>As communicated by plan or refer to ID card</td>
<td></td>
</tr>
<tr>
<td>SilverScript</td>
<td>004336*</td>
<td>1-866-693-4620</td>
<td>1-855-503-6054</td>
</tr>
<tr>
<td>Non-SilverScript</td>
<td>004336*</td>
<td>As communicated by plan or refer to ID card</td>
<td>1-855-238-9379</td>
</tr>
<tr>
<td>NEJE (New England Joint Enterprise)</td>
<td>004336*</td>
<td>1-866-693-4620</td>
<td>1-844-635-3407</td>
</tr>
<tr>
<td>Aetna</td>
<td>610502</td>
<td>1-800-238-6279</td>
<td></td>
</tr>
</tbody>
</table>

Secondary RXBINS and Plan sponsor-specific RXBINS and phone numbers may apply as specified in pharmacy notifications or the Caremark Payer Sheets found online at www.caremark.com/pharminfo.

*Puerto Rico Providers call toll-free 1-800-842-7331.

Pharmacy Help Desk representatives will use reasonable efforts to assist Providers. However, Pharmacy Help Desk representatives are not able to provide professional advice with the respect to the provision of Pharmacy Services. Pharmacy Help Desk representatives do not have authority to waive or modify Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance).

10.03 Credentialing

10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies
Provider agrees to comply with the following provisions:

1. Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section 10.03.02 Federal Health Care Programs Participation Exclusion of the Provider Manual.
2. Provider has a record retention policy in place that complies with CMS’s minimum of 10-year record retention requirement and with other applicable state Law.
3. Provider has in place and provides FWA training to all employees and managers (who are directly or indirectly involved with the administration of delivery of Part D benefits) within thirty (30) days of their date of hire and annually thereafter.
4. Provider tracks employee and manager attendance for any training conducted.
5. Provider must provide a copy of the training materials upon request.
6. Provider attests that if any services that support the Provider Agreement or if any of its subsidiaries or affiliates are delegated, the performance of those services is monitored by Provider to ensure compliance with the applicable Medicare Part D requirements.
7. Provider has entered into written arrangements with its subcontractors which provide for revocation of the delegation activities or specify other remedies in instances when CMS or Caremark or any of its subsidiaries or affiliates has determined that the parties have not performed satisfactorily.
8. Provider certifies that it is free of any conflicts of interest (within the meaning of the CMS Prescription Drug Benefit Manual, Chapter 9) in administering or delivering its Pharmacy Services, and will require its managers, officers and directors responsible for the administration or delivery of Pharmacy Services for Part D Enrollees to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any such conflict of interest.

10.03.02 Federal Health Care Programs Participation Exclusion

A. Prescriber
In accordance with CMS requirements, Part D Plan Sponsors must have policies and procedures in place to implement a comprehensive program to detect, prevent and control fraud, waste and abuse, including a process to identify any claims that were submitted for drugs that were prescribed by an excluded Prescriber, and a process to report and properly repay any overpayments resulting from inaccurate payments in accordance with CMS policy. The guidance also states that Part D Plan Sponsors must not pay for drugs prescribed by a Prescriber excluded by either the Health and Human Services-Office of Inspector General (HHS-OIG) or System for Award Management (SAM).

Caremark implemented an automated point-of-sale process to deny Part D Claims for drugs prescribed by excluded Prescribers. Provider may receive the following reject:

Reject A1 <<Prescriber is Federally Excluded>>

If Provider receives this electronic message, do not resubmit the claim for processing unless, in Provider’s professional judgment, it is an emergency situation. If it is an emergency situation, call the appropriate Pharmacy Help Desk contact number referenced in this section.

The Caremark point-of-sale reject is intended to assist Provider in the identification of excluded Prescribers, but does not serve as a substitute for the Provider’s own comprehensive program to identify claims for drugs prescribed by excluded Prescribers. Provider must maintain a comprehensive program to identify claims for drugs prescribed by an excluded Prescriber in the event that a point-of-sale reject does not occur.

B. Precluded Prescriber
In accordance with CMS guidance, claims prescribed by an individual on the Preclusion List will reject with the following or similar reject:

Reject 929 <<Prescriber ID is precluded>>

The Preclusion List includes prescribers who meet one of the following conditions:

- Prescribers that are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Prescribers that have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Such conduct includes, but is not limited to, felony convictions and Office of Inspector General (OIG) exclusions.

There is no override for this reject. Impacted Part D Enrollees that have concerns or need assistance finding a new Prescriber should contact Medicare’s toll-free customer care operations at 1-800-MEDICARE (1-800-633-4227).

C. Pharmacy Provider
Pharmacy Provider must review the OIG LEIE and the SAM Excluded Prescriber lists. Provider must not submit any claim to Caremark for a prescription written by an excluded Prescriber, nor should a Pharmacy Provider submit
caremark
provider manual

CONFIDENTIAL AND PROPRIETARY - FOIA EXEMPT - DO NOT DISCLOSE

Medicare Part D

10.04 Pharmacy Services and Standards

10.04.01 Plan Identification Cards

Provider must submit claims to the claims adjudication system whenever the Part D Enrollee’s plan identification card is presented to or on file with Provider, unless the Part D Enrollee expressly requests that a particular claim not be submitted.

10.04.02 General Procedures for Acknowledgement of Enrollment Letters

In order to comply with CMS requirements, Providers should honor Part D Enrollee acknowledgement of enrollment letters if presented to Provider in place of identification cards.

An acknowledgement letter is a letter that qualified Part D Enrollees receive from their Part D Plan in advance of the distribution of Part D Plan identification cards. The letter should contain sufficient information in order to verify a Part D Enrollee’s eligibility and to submit claims to the appropriate location in order for adjudication to occur. Note, letters confirming initial information was received but has yet to be confirmed or processed may not constitute a Part D acknowledgement letter.

If there is insufficient/inaccurate information on the letter or if the claim rejects, the following steps may be useful whether the information was obtained from an acknowledgement letter, an identification card or from the Part D Enrollee directly:

1. If a Part D Enrollee’s eligibility cannot be verified, send an enhanced E1 transaction to the Transaction Facilitator (RelayHealth) to verify the Part D Enrollee eligibility and to obtain information necessary to process claims. It is Provider’s responsibility to verify Part D Enrollee is the Part D Enrollee identified in the response.

2. If a Part D Enrollee’s eligibility cannot be verified in Step 1 but Caremark is the processor, contact the appropriate Pharmacy Help Desk phone number. Refer to sections 1.04 Pharmacy Help Desk and 10.02.02 Medicare Part D Calls to the Pharmacy Help Desk of the Provider Manual.

3. If a Part D Enrollee’s eligibility cannot be verified in Step 2, call 1-800-MEDICARE to verify the Part D Plan under which the Part D Enrollee is enrolled, and if possible, verify the Part D Enrollee’s eligibility information.

10.04.03 Best Available Evidence

CMS created the Best Available Evidence (BAE) policy requiring Part D Plans to establish the appropriate cost-sharing for low-income Part D Enrollees when presented with evidence that the Part D Enrollee’s information was not accurate. As a result, a CMS best practice is for Providers and Part D Plans to work to resolve these issues at the point of sale when Part D Enrollees present appropriate evidence of correct low-income status.

1. Provider should initiate the BAE process in order for a change to a Part D Enrollee’s low-income status to occur if Provider is presented with one or more of the following acceptable forms of evidence from Part D Enrollees:
   a. A copy of the Part D Enrollee’s Medicaid card which includes the Part D Enrollee’s name and an eligibility date during the discrepant period;
   b. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the State staff person who verified the Medicaid status during the discrepant period;
   c. A copy of a State document that confirms active Medicaid status during the discrepant period;
   d. A printout from the State electronic enrollment file showing Medicaid status during the discrepant period;
   e. A screen print from the State’s Medicaid systems showing Medicaid status during the discrepant period; or
   f. Other documentation provided by the State showing Medicaid status during the discrepant period.

2. In addition, any one of the following forms of evidence from Part D Enrollees may establish that they are institutionalized and qualify for zero cost-sharing:
   a. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
b. A copy of a State document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
c. A screen print from the State’s Medicaid systems showing that individual’s institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

3. Acceptable documents that may be used as BAE for demonstrating receipt of Home and Community-Based Services (HCBS) include:
   a. A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the Part D Enrollee’s name and HCBS eligibility date during a month after June of the previous calendar year;
   b. A copy of a State-approved HCBS Service Plan that includes the Part D Enrollee’s name and effective date beginning during a month after June of the previous calendar year;
   c. A copy of a State-issued prior authorization approval letter for HCBS that includes the Part D Enrollee’s name and effective date beginning during a month after June of the previous calendar year; or
d. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year.

4. Once Provider has the required acceptable form(s) of evidence, Provider should either:
   a. Contact the Pharmacy Help Desk for appropriate Plan Sponsor contact information; or
   b. Consult the annual Caremark Medicare Part D Plan Sponsor chart distributed to Providers annually.

If urgent, Caremark will work with Provider and Plan Sponsor to update eligibility and resolve the situation; otherwise, Provider should work directly with the Plan Sponsor to submit the acceptable BAE in order for a change to a Part D Enrollee’s low-income status to occur through standard protocol.

10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in LICS/LIS
In order to avoid any interruptions to receiving drug therapy for Part D Low-Income Subsidy (LICS/LIS) eligible Part D Enrollees who have received a notification from CMS indicating a status change, the Part D Enrollee must apply/re-apply through the Social Security Administration, or he or she may have adjusted copayment and premium liabilities in the future. Providers are encouraged to assist these Part D Enrollees by:

- Helping the Part D Enrollee submit LICS/LIS applications
- Referring the Part D Enrollee to the Social Security Administration at:
  1-800-772-1213
  www.ssa.gov/medicareoutreach2/index.htm

10.04.05 Auto-Ship Refill Programs
Providers may offer Part D Enrollees the option of enrolling in automatic refill programs. Providers must offer such programs in compliance with CMS requirements, including (a) permitting Part D Enrollees to opt-out of auto-ship refill program at any time; (b) providing Part D Enrollees with two (2) shipping reminders prior to shipping; and (c) granting Part D Enrollees a refund for any unwanted fill.

Provider must provide the Part D Enrollee with two (2) shipping reminders before each auto-ship refill order to give the Part D Enrollee sufficient time to cancel or make changes to an order. Shipping reminders must include an approximate shipping date range, information on how to obtain the cost-share for an upcoming auto-ship refill order, and instructions on how to cancel an order. CMS allows Provider to send the shipping reminder based on the Part D Enrollee’s preferred method of communication that includes phone, email, text, direct mailing, or other comparable means of communication.

10.05 Claims Submission

10.05.01 Unique RXBIN/RXPCN Requirement - Medicare Part D
Provider must include RXBIN, RXPCN, and RXGRP values on submitted claims. Part D Enrollee profiles must be updated accordingly. Caremark will continue to communicate unique RXBIN/RXPCN/RXGRP combinations of Plan Sponsors. Refer to the Caremark Payer Sheets at www.caremark.com/pharinfo.

10.05.02 Payment of Clean Claims
In accordance with 42 C.F.R. § 423.520, payment for clean claims (that have been determined to be eligible for
payment) will be made to Provider within fourteen (14) days (for electronically submitted claims), or thirty (30) days (for non-electronically submitted claims) from the date the claim is received. A clean claim is defined as a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. Claims from a Provider whose participation status has been suspended, in accordance with section **6.09 Provider Suspension** of the Provider Manual, are not eligible for payment unless and until such time as Provider’s suspension has been lifted and any offset against amounts owed to Caremark has been processed.

**10.05.03 Electronic Prescribing**


**10.05.04 Prescription Origin Code and Fill Number**

Provider must use the Prescription Origin Code when submitting all Medicare Part D claims. Original fill claims submitted without one of the values below will reject.

The Prescription Origin Code should be placed in the 419-DJ field, and the following values should be used:

1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Pharmacy

The Fill Number should be placed in the 403-D3 field, and the following values should be used:

ØØ = Original dispensing
Ø1 to 99 = Refill number

**10.05.05 Improving Drug Utilization Review Controls**

CMS discusses the need for Medicare Part D Plan Sponsors to employ more effective concurrent and retrospective DUR programs to address overutilization of medications in order to protect Part D Enrollees and to comply with drug utilization management requirements at 42 C.F.R. § 423.153, et seq.

Claims adjudication system edits have been implemented to improve control at the point of sale and ensure that DUR processes comply with CMS requirements for all classes of drugs.

The chart below describes the DUR reject edits and associated Professional Service (PPS) Codes that may be used to override the reject when applicable. Enhanced reject messaging will return to help clarify the reason for the reject. Be sure to review the entire DUR message for instructions which may require viewing additional screens in your software. Since a single claim may trigger more than one concurrent DUR reject, Providers will need to enter the corresponding PPS codes documenting the action for each reject.

The chart below may be used to assist with entering the appropriate PPS Codes.

<table>
<thead>
<tr>
<th>Edit Name and Description</th>
<th>Reject Message</th>
<th>Reason for Service Code</th>
<th>PPS Professional Service Code</th>
<th>Result of Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine/Opioid: Identifies opioid use after treatment with a buprenorphine product.</td>
<td>Reject 88- PPS CODE REQD: HX BUPENORP; EXCL OPIOID</td>
<td>“DM”</td>
<td>MØ - Prescriber consulted</td>
<td>1B - RHP determines alert is not relevant for the Rx and member</td>
</tr>
<tr>
<td>Cumulative APAP Check: Checks for excessive cumulative acetaminophen (cAPAP) utilization across multiple prescriptions.</td>
<td>Reject 88- PPS CODE REQD: APAP EXCEEDS 4GM/DAY</td>
<td>“AT”</td>
<td>PM - Patient monitoring</td>
<td>1C - Filled with a different dose</td>
</tr>
<tr>
<td><strong>Edit Name and Description</strong></td>
<td><strong>Reject Message</strong></td>
<td><strong>Reason for Service Code</strong></td>
<td><strong>PPS Professional Service Code</strong></td>
<td><strong>Result of Service Code</strong></td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------</td>
<td>----------------------------</td>
<td>----------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Cumulative Morphine Milligram Equivalent (cMME): Checks for excessive opioid utilization via cumulative morphine equivalent dose (cMED) across multiple drugs and prescriptions.</td>
<td>Soft Reject 922/88-EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD. Hard Reject 922/G4/88-EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD. PRESCRIBER MUST CALL XXX-XXX-XXXX WHEN CLINICAL EXCEPTION APPLIES</td>
<td>“HC”</td>
<td>RO - Pharmacist consulted other source</td>
<td>1D - Filled with different directions 1F - Filled with a different quantity 1G - Filled with a Prescriber approval 2A - RPH determines Rx should not be filled as written 4B - Dispensed, Palliative Care 4C - Dispensed, Hospice 4D - Dispensed, Cancer Treatment</td>
</tr>
<tr>
<td>Excessive Controlled Substance Enhancement: Intended to capture multiple controlled substance (CS) claims (for the same drug or different controlled substances) within the past thirty (30) days.</td>
<td>Reject 88–PPS CODE REQD: MULT CII-V IN LAST 30 DAYS</td>
<td>“DM”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose Check - Max Dose Multiplier: Intended to identify claims with excessively high doses. Applies to all drugs.</td>
<td>Reject 88–PPS CODE REQD: MAX DOSE EXCEEDED – 5X MAX</td>
<td>“HD”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Pharmacies: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class at four or more pharmacies. Applies to all drugs.</td>
<td>Reject 88–PPS CODE REQD: &gt;=4 PHARMACIES/ SAME DRUG CLASS</td>
<td>“DM”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Prescribers: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class prescribed by four or more prescribers. Applies to all drugs.</td>
<td>Reject 88–PPS CODE REQD: &gt;=4 PRESCRIBERS/ SAME DRUG CLASS</td>
<td>“DM”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Long Acting Opioids: Designed to identify Part D Enrollees on two or more long acting opioids.</td>
<td>Reject 88 – PPS CODE REQD: 2 OR MORE LA OPIOIDS</td>
<td>“TD”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid/Benzodiazepine Drug Interaction: Designed to identify Part D Enrollees receiving a medication from both classes of drugs.</td>
<td>Reject 88 – PPS CODE REQD: DRUG INT OPIOIDS AND BENZO</td>
<td>“DD”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Day Opioid Naïve Edit: Designed to identify Part D Enrollees with no history of an opioid in the past 108 days and limit their initial supply to 7 days or less.</td>
<td>Reject 925: IF OPIOID/CANCER HISTORY, RPH USE SCC 10 OR SUBMIT 7 DS OR CALL XXX-XXX-XXXX</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
Do not save PPS and Result of Service Codes on any prescriptions that have previously rejected for DUR. For an initial fill or any refills, Provider cannot pre-empt the reject by entering PPS Codes prior to the first submission of the claim. Allow the reject to occur and then enter the appropriate PPS Codes on resubmission. Entering PPS Codes prior to allowing the claim to reject will cause the claim to continue to reject.

**10.05.06 Medicare Part D Claims Requiring Overrides**

**A. Natural Disasters**

Caremark is dedicated to assisting Providers and Part D Enrollees in response to emergencies resulting from natural disasters, severe weather, etc., where medical records are either destroyed or not accessible. Refer to section **4.09 Natural Disasters** of the Provider Manual. Refer to section **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual for contact information.

**B. Network Access**

Some Part D Enrollees are allowed by their Part D Plan to obtain prescriptions at out-of-network pharmacies. However, Part D Enrollees may be required to submit paper claims for reimbursement eligible out-of-network expenses and provide documentation as to why the claims were filled at an out-of-network pharmacy. There are no changes to this process for Part D Enrollees residing in the emergency area.

**C. Refill-Too-Soon and Excessive Utilization Rejects**

CMS will ensure that rules preventing early refills are waived. This will assist those Part D Enrollees who left or lost their prescription during emergencies.

**10.05.07 General Medicare Part D Submission Requirements for COB**

Provider must not hold an Eligible Person who is dually eligible for both Medicare and Medicaid liable for Medicare Part A and B Patient Pay Amounts when Medicaid is responsible for paying such amounts for Qualified Medicare Beneficiaries; Provider must accept Caremark’s payment as payment in full or bill the appropriate state Medicaid.

For Medicare Secondary Payer (MSP) claims, the primary Medicare Part D RXBIN/RXPCN/RXGRP combinations should be submitted on the COB claim (refer to the Caremark Plan Sponsor grid within the Pharmacy Portal, login required, at www.rxservices.cvscaremark.com."

For COB claims that are supplemental to Medicare Part D, Provider must submit the corresponding RXBIN (refer to section **1. General Information** of the Provider Manual) unless otherwise communicated by Caremark. Plans offering coverage that is supplemental to Medicare Part D may require specific COB RXPCNs or RXGRPs as communicated or printed on ID cards. Providers may receive notice of plan-specific claims processing information.

For primary Part D Plan Sponsors who have implemented STCOB, the claim adjudicates against both primary and secondary plans before returning one final response to Provider. Caremark may return a message in the pharmacy response indicating STCOB was used. STCOB is limited to certain Plan Sponsors who have elected to administer two benefits that will be coordinated automatically by Caremark for eligible Part D Enrollees.

Refer to the Caremark Payer Sheets referenced in Appendix A or additional details on how to submit Medicare Part D COB claims.

**10.05.08 Formulary Transition Fill Process**

All Part D Plans are required by CMS to provide a formulary transition plan for Part D Enrollees who are eligible for a transition supply. The intent of the transition plan is to ensure immediate short-term coverage for Part D Enrollees who are either new to a Part D Plan or who otherwise qualify for a Transition Fill (TF). Providers are required to submit TF-eligible claims for eligible Part D Enrollees to ensure these Enrollees are able to receive the TF’s to which they are entitled. This will allow Part D Enrollees to continue ongoing therapies while either transitioning to an equivalent formulary drug, or pursuing prior authorizations or formulary exceptions. Drugs excluded under Part D are not eligible for TF.

Caremark provides TF coverage to eligible Part D Enrollees under the circumstances indicated in the “Transition Fill Plan” below when Part D drugs:

- are non-formulary; or
- are formulary and require prior authorization or step therapy under a plan’s utilization management rules; or
- have quantity limits or daily dose limits that are not safety related.
TF-eligible claims will process and pay upon initial submission and messages will indicate when claims have paid under TF rules. Providers do not need to resubmit a TF Prior Authorization code for TF-eligible claims to adjudicate upon initial submission. The messages listed below will return with paid TF claims so Providers can remind Part D Enrollees of actions that should be taken to ensure access to prescription drugs in accordance with Part D formularies and benefits. Provider will receive one of the following messages with the paid claim under TF rules:

- <<Paid under Transition Fill - Non-formulary>>
- <<Paid under Transition Fill - PA required>>
- <<Paid under Transition Fill - Other Reject>> (Note: other rejects represented by this message include Step Therapy, Quantity Limits, Daily Dose, etc.)

The following drugs are not TF eligible:

- Drugs not covered under Part D.
- Drugs that are dispensed for reasons other than medically accepted indications.
- Drugs that are dispensed outside of safe utilization recommendations.

For submitted claims not eligible for TF,

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>> is intended to remind Provider to provide the required Part D Notice of Appeal Rights directly to Part D Enrollees should he or she want to appeal rejected claims with Part D Plans. Notice must be given directly to Part D Enrollees any time this reject occurs on a claim.

The Transition Supply is an approved month’s supply for both the outpatient and the long-term care patient. No changes were made to the long-term care Emergency Supply, which remains a 31-day supply.

**Outpatient Transition Fill**

<table>
<thead>
<tr>
<th>Transition Fill Condition</th>
<th>Description</th>
<th>Allowed TF Supply for the Retail Setting</th>
</tr>
</thead>
</table>
| Part D Enrollee who is newly enrolled in Plan | • Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period  
• Transition of newly eligible Part D Enrollee from other coverage  
• Transition of Part D Enrollee switching from one plan to another after start of contract year | An approved month’s supply as specified in the patient’s benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage in the new Plan |
| Some renewing Part D Enrollee across Plan contract years | • Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within the look-back period (established by the plan) from date of claim and previous claim not TF for the same reason  
• If Part D Enrollee has not transitioned before beginning of new Plan benefit year | An approved month’s supply as specified in the patient’s benefit plan, which can be a cumulative amount within the first ninety (90) days of coverage effective at the beginning of the new contract year |
| Part D Enrollee requesting exception and decision still pending | Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted | Contact the Pharmacy Help Desk for Transition Extension Overrides under this Condition |
For questions, concerns or issues related to Transition Fill claim processing, refer to section **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual for the appropriate telephone number to call.

**10.05.09 Insulin Coverage**
Medicare Part D Plans cover injectable insulin not used with an insulin infusion pump. Medicare Part B covers external insulin pumps and the insulin that the device uses under durable medical equipment.

**10.05.10 Pro-Rated Daily Cost Share**
For applicable plans with a copayment benefit, Part D Plan Sponsors must establish and apply a daily cost-sharing rate whenever certain prescriptions (depending on the drug) are dispensed by Provider for less than the Part D Plan Sponsor’s defined one-month supply in accordance with 42 C.F.R. § 423.153(b)(4)(i).

Caremark will apply a daily cost-sharing rate for a Covered Part D Drug that is dispensed for less than the plan-defined one-month supply. If a claim applies a daily cost-sharing rate Provider may receive the following message:

```
<<023 - Prorated copayment applied based on days supply. Plan has prorated the copayment based on days supply>>
```

The daily cost-sharing rate applies if the drug (brand or generic) is in the form of a solid oral dose and is dispensed for a days supply less than the plan-defined one-month supply under applicable Law, except for the following types of drugs:

- Solid oral doses of antibiotics
- Solid oral doses 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 to assist patients with compliance
- Non-Part D drugs, unless the Part D Plan has specified that copay proration extends to covered drugs that are treated as non-Part D under their benefit plans
- Drugs dispensed by out-of-network providers

**10.05.11 Medicare Part B and Medicare Part D Drug Coverage Determinations**
For specific rejects addressing (1) drugs excluded from Part D coverage as mandated by the Medicare Modernization Act; and (2) drugs that are covered under Medicare Part B for the designated Part D Enrollee, refer to the NCPDP Payer Sheets at [www.caremark.com/pharminfo](http://www.caremark.com/pharminfo).

Provider must enter an appropriate Patient Residence Code for all Part B vs. Part D claims. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

Caremark uses the following reject codes for drugs that may be covered under Medicare Part B for the designated Medicare beneficiary:

<table>
<thead>
<tr>
<th>Reject Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>569</td>
<td>Provide Notice: Medicare Prescription Drug Coverage and Your Rights</td>
</tr>
<tr>
<td>75</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>A6</td>
<td>This Product/Service May Be Covered Under Part B</td>
</tr>
</tbody>
</table>
Secondary messaging may also be returned. The secondary message is as follows:

<<B vs D Inquiry RPH Call XXX-XXX-XXXX>>

When Provider receives a reject with secondary messaging and calls the number included in the reject, the Pharmacy Help Desk representative, who is specifically trained to handle Part B vs. Part D determinations, will present a series of criteria to Provider. Based on the information obtained from the pharmacist, the Pharmacy Help Desk representative will be able to promptly assist Provider with processing the Part D claim, if appropriate. This process only applies to certain drug categories and select Part D Plans. For drugs not handled by the Pharmacy Help Desk, the reject message will indicate that a Prior Authorization is required and include the number for initiating a coverage determination.

10.05.12 End Stage Renal Disease Claim Processing
ESRD “Always” Drugs

CMS guidance requiring Part D Plans to impose a prior authorization edit for the four categories of drugs that are “always” used to treat End Stage Renal Disease (ESRD) remains in effect. CMS states that if the “always” drug was used to treat ESRD, it is payable under the Medicare Part B Bundled Payment to the dialysis center, regardless of whether or not dialysis treatment was received on the date the drug was prescribed or dispensed. Provider must maintain prescription record documentation for Part D Enrollees which contains the diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD).

For the ESRD “Always” Drugs, Caremark uses the following reject codes for drugs that may be covered under Medicare Part B Bundled Payment for ESRD:

<table>
<thead>
<tr>
<th>Reject Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>569</td>
<td>Provide Notice: Medicare Prescription Drug Coverage and Your Rights</td>
</tr>
<tr>
<td>75</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>A4</td>
<td>This Product May Be Covered Under the Medicare B Bundled Payment to an ESRD Dialysis Facility</td>
</tr>
</tbody>
</table>

In addition to these rejects, secondary messaging will be returned. The secondary message is as follows:

<<Part B vs D: To Resolve RPh Call XXX-XXX-XXXX>>

10.05.13 Prescriber Identification for Medicare Part D Claims

For all Medicare Part D claims, accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claims adjudication, clinical services, Plan Sponsor initiatives, and audits. In addition, CMS requires a valid and active individual Prescriber National Provider Identifier (NPI) on all claims. Failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI, DEA number or any other number or identifier (e.g., hospital, clinic, or pharmacy identification number) in the prescriber identification field which does not represent an individual Prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate submission clarification code (SCC) to bypass the reject. Per CMS, Part D Plan Sponsors are required to only report Type 1 (Individual) NPIs on PDE records. Type 2 (group/organizational identifier) NPIs are not accepted for Prescribers.
Providers must obtain an individual NPI. Any claim submitted with an invalid NPI will reject with the following or similar reject message:

<table>
<thead>
<tr>
<th>Reject Code</th>
<th>Reject Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>Plan’s Prescriber database indicates Prescriber ID submitted is associated with a deceased Prescriber and the Date of Fill/Service of the claim is one year after the deceased date for a non-controlled substance or the Date of Fill/Service of the claim is 180 days after the deceased date for controlled substance</td>
</tr>
<tr>
<td>42</td>
<td>Plan’s Prescriber database indicates the Prescriber ID submitted is inactive or expired</td>
</tr>
<tr>
<td>43</td>
<td>Plan’s Prescriber database indicates the associated DEA to the submitted Prescriber ID is inactive</td>
</tr>
<tr>
<td>44</td>
<td>Plan’s Prescriber database indicates the associated DEA to the submitted Prescriber ID is not found</td>
</tr>
<tr>
<td>46</td>
<td>Plan’s Prescriber database indicates the associated DEA to the submitted Prescriber ID does not allow this drug DEA class</td>
</tr>
<tr>
<td>56</td>
<td>Plan’s Prescriber database indicates the Prescriber ID submitted is not found</td>
</tr>
<tr>
<td>619</td>
<td>Plan’s Prescriber database indicates the Prescriber qualifier is not equal to 01</td>
</tr>
</tbody>
</table>

Below are the various SCC values that may be submitted for the invalid Prescriber ID rejects once Provider has confirmed the ID submitted is valid and the reject for invalid Prescriber ID is not appropriate (the claim is still subject to audit review and chargeback):

<table>
<thead>
<tr>
<th>Reject Code</th>
<th>SCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>42 - Prescriber ID Submitted is valid and prescribing requirements have been validated</td>
</tr>
<tr>
<td>42</td>
<td>42 - Prescriber ID Submitted is valid and prescribing requirements have been validated</td>
</tr>
<tr>
<td>43</td>
<td>43 - Prescriber’s DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescriber’s DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule</td>
</tr>
<tr>
<td>44</td>
<td>43 - Prescriber’s DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescriber’s DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule</td>
</tr>
<tr>
<td>46</td>
<td>46 - Prescriber’s DEA has prescriptive authority for this drug DEA Schedule</td>
</tr>
<tr>
<td>56</td>
<td>42 - Prescriber ID Submitted is valid and prescribing requirements have been validated</td>
</tr>
<tr>
<td>619</td>
<td>42 - Prescriber ID Submitted is valid and prescribing requirements have been validated</td>
</tr>
</tbody>
</table>

For additional information on identification of a foreign Prescriber, refer to the Caremark Payer Sheets at www.caremark.com/pharminfo.

10.05.14 Claims Submission Window for Medicare Part D
Providers have ninety (90) days from original date of fill to receive paid transactions including submissions, reversals and resubmissions of Medicare Part D Claims. Provider Universal Claim Forms (UCFs) will be accepted and processed up to March 31st after the close of the previous plan year in which the date of fill occurred when accompanied by a reasonable explanation why the Medicare Part D Claim could not be submitted and processed online. This timely filing window aligns with the CMS processing windows. Provider UCFs should be clearly identified as “Medicare Part D” claims and should be mailed to the following address:
Refer to section 10.07.02 LTC Pharmacies Timely Claim Submission of the Provider Manual regarding timely submission of Medicare Part D LTC claims.

10.05.15 Medicare Part D Claims Adjustment
Caremark may adjust paid claims to correct errors or reflect changes in eligibility of Part D Enrollee, to the extent consistent with applicable Law. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider.

Provider must charge Part D Enrollees the correct cost-sharing amount in accordance with the Part D Plan benefit and as required by CMS. For all LTC claims submitted by Providers for Part D Enrollees, and therefore, for whom Caremark has assessed cost-sharing that has been borne by Provider, Caremark will reimburse Provider for such amounts. Refer to section 10.06.02 Pharmacy Service Type and Patient Residence Requirements of the Provider Manual.

1. Provider agrees that by accepting payment from Caremark for these amounts assessed against Part D Enrollees, Provider is certifying that:
   a. Provider has not collected or otherwise waived such amounts from such Part D Enrollees or their representatives;
   b. Provider is in fact carrying a debt for the amounts charged to such Part D Enrollee; and
   c. The amounts reimbursed by Caremark are appropriate, owed, and payable.

2. In cases where Part D Enrollees claims are retroactively identified as inappropriate overpayments to Provider, Caremark will adjust Provider for such amounts. Provider is responsible for:
   a. Collecting outstanding Patient Pay Amount balances from Part D Enrollees; and
   b. Accurately debiting and/or crediting Part D Enrollees to help maintain accurate True Out-of-Pocket (TrOOP) balances for these retroactively identified claims.

10.06 Network Participation and Payment

10.06.01 Drug Pricing
Notwithstanding anything to the contrary, Caremark utilizes Medi-Span as reference for drug prices. Drug price files are updated every business day. An initial update to the drug price file occurs on January 1, or the following business day each year. Point-of-service claims are adjudicated, and Provider is reimbursed in accordance with these updates.

Provider may access the Caremark Pharmacy Portal at www.rxservices.cvscaremark.com to receive advance notice of changes to MAC for Medicare Part D Claims.

10.06.02 Pharmacy Service Type and Patient Residence Requirements
To ensure appropriate adjudication and reimbursement, Providers must submit valid Pharmacy Service Type and Patient Residence values on all claims. Approved Part D Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) values must be submitted accurately to identify claim type. Refer to the NCPDP Payer Sheets at www.caremark.com/pharminfo.

<table>
<thead>
<tr>
<th>CMS Acceptable Code Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Service Type – Field 147-U7</td>
</tr>
<tr>
<td>Patient Residence – Field 384-4X</td>
</tr>
</tbody>
</table>
All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply.

The only valid claim submission values for Pharmacy Service Type (Field 147-U7) and Patient Residence (Field 384-4X) are the supported values listed in the NCPDP External Code List (ECL). Submitted values not supported in the ECL will cause the claim to reject with:

- Reject U7: <<M/I Pharmacy Service Type>>
- Reject 4X: <<M/I Patient Residence>>

A blank value will not be allowed in either field for Medicare Part D claims.

As recommended by NCPDP, Caremark accepts the below values to ensure appropriate adjudication and reimbursement. Provider must be in the specific Medicare Part D network in order to submit these codes and receive appropriate payment. Home infusion and Long-term Care Claims must meet the CMS qualifications (e.g., skilled nursing unit) in order to submit these codes and receive appropriate payment.

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>Claim/Service Type</th>
<th>Pharmacy Service Type (Field 147-U7)</th>
<th>Patient Residence (Field 384-4X)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail</td>
<td>Retail</td>
<td>01</td>
<td>01</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>HIF</td>
<td>03</td>
<td>04</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>ALF</td>
<td>03</td>
<td>04</td>
</tr>
<tr>
<td>Long-term Care</td>
<td>LTC</td>
<td>05</td>
<td>03</td>
</tr>
<tr>
<td>Long-term Care</td>
<td>ICF/IID</td>
<td>05</td>
<td>09</td>
</tr>
<tr>
<td>Assisted Living Facility</td>
<td>ALF</td>
<td>05</td>
<td>04</td>
</tr>
</tbody>
</table>

For Claims submitted for LTC Part D Enrollees with a Patient Residence of 03, an SCC value in field 420-DK is required for brand oral solids. The above table does not include all Patient Residence and Pharmacy Service Type combinations.

### 10.07 Special Instructions for Participating LTC Providers

The following information is applicable to Providers participating in the Caremark and Part D Plan-specific LTC Medicare Part D networks, unless specified otherwise.

#### 10.07.01 Pharmacies Serving LTC Facilities

**Prescription Drug Benefit Manual – Section 40.3.1**

Given the unique circumstances of the LTC setting, Part D Enrollees will generally not present the prescription to Provider. In most instances, either the treating Prescriber or his or her authorized agent sends the prescription to Provider. If there is an issue with a requested prescription, Provider is required to contact the treating Prescriber or his or her authorized agent and the Prescriber determines what course of action is appropriate (e.g., the Prescriber may prescribe a different medication or request an exception).

If Provider is off-site, Provider must send (fax or deliver) the CMS-10147 Pharmacy Notice to the location in the LTC facility designated to accept such notices.

If Provider is on-site, Provider must deliver the notice to the location in the LTC facility designated to accept such notices. The LTC facility staff is responsible for providing the Part D Enrollee (or the Part D Enrollee’s appointed representative) and the Part D Enrollee’s treating Prescriber with the notice. A copy of the notice should be placed in the Part D Enrollee’s file at the LTC facility (refer to Appendix G for a copy of the notice in English and Spanish).
10.07.02 LTC Pharmacies Timely Claim Submission

Participating LTC Providers will have no less than thirty (30) days, and no more than ninety (90) days to submit claims (42 C.F.R. 423.505(b)(20)) from the original date of fill. This includes electronically submitted claims and non-electronically submitted claims from original date of fill. Non-participating LTC Providers have three (3) years from the original date of fill to file claims.

The requirement above does not eliminate the requirement specified in CMS policy memo dated May 25, 2007, for Part D Plan Sponsors to provide new timely claims filing period for claims incurred by dual-eligible Part D Enrollees during a period of retroactive Part D enrollment.

Provider UCFs should be clearly identified as “Medicare Part D LTC” claims, include the appropriate Pharmacy Service Type and Patient Residence values and should be mailed to the following address:

RXBINs 004336, 610591, 610415: RXBIN 610502:

Long-term Care (LTC) Claims: Aetna Long-term Care (LTC) Claims
Attn: Medicare Part D LTC Attn: Aetna Medicare Part D LTC
PO Box 52419 PO Box 14023
Phoenix, AZ 85072-2419 Lexington, KY 40512-4023

10.07.03 LTC Billing

Provider must dispense certain brand oral solid Covered Part D Drugs in quantities of fourteen (14) days or less, unless an exemption applies. Caremark has implemented a dispensing fee incentive for those LTC Part D brand and generic drugs in accordance with CMS regulations. Provider agrees to submit claims to Caremark’s claim adjudication system for LTC Pharmacy Services. Provider must bill Caremark immediately after dispensing or within thirty (30) days after the dispensing event. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws.

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of day supply. “Brand oral solids” are limited to brand products with the following exceptions to the appropriate days supply (ADS) dispensing rule:

- Generic drugs (ANDA/non-specified)
- Solid oral doses of antibiotics
- Solid oral doses in packaging that cannot be broken (e.g., oral contraceptives)

Other exceptions—Providers, Part D Enrollees and coverage situations—include:

- Assisted Living Facilities (ALF)
- Medicare as a Secondary Payer (MSP)
- Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) and Institutes for Mental Disease (IMD)
- Indian Health Service, Tribal 638, and Urban Indian Health (I/T/U)

Four fields have been utilized to accommodate ADS dispensing requirements: Patient Residence Code, Pharmacy Service Type, Submission Clarification Codes (SCC) and Special Package Indicator (SPI). Refer to section 10.06.02 Pharmacy Service Type and Patient Residence Requirements of the Provider Manual.

Submission Clarification Codes:

<table>
<thead>
<tr>
<th>NCPDP Field 420-DK</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>LTC dispensing: 14 days or less not applicable (N/A) – 14 days or less dispensing is N/A due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e., vacation supply, leave of absence, e-kit, spitter dose). Medication quantities are dispensed as billed</td>
</tr>
<tr>
<td>22</td>
<td>LTC dispensing: 7 days – Pharmacy dispenses medication in 7-day supplies</td>
</tr>
</tbody>
</table>
### NCPDP Field 420-DK

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>LTC dispensing: 4 days – Pharmacy dispenses medication in 4-day supplies</td>
</tr>
<tr>
<td>24</td>
<td>LTC dispensing: 3 days – Pharmacy dispenses medication in 3-day supplies</td>
</tr>
<tr>
<td>25</td>
<td>LTC dispensing: 2 days – Pharmacy dispenses medication in 2-day supplies</td>
</tr>
<tr>
<td>26</td>
<td>LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1-day supplies</td>
</tr>
<tr>
<td>27</td>
<td>LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4-day, then 3-day supplies</td>
</tr>
<tr>
<td>28</td>
<td>LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2-day, then 2-day, then 3-day supplies</td>
</tr>
<tr>
<td>29</td>
<td>LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekends</td>
</tr>
<tr>
<td>30</td>
<td>LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes)</td>
</tr>
<tr>
<td>31</td>
<td>LTC dispensing: Per med pass dispensing – Remote dispensing per med pass</td>
</tr>
<tr>
<td>32</td>
<td>LTC dispensing: PRN on demand – Remote dispensing on demand as needed</td>
</tr>
<tr>
<td>33</td>
<td>LTC dispensing: 7 days or less cycle not otherwise represented</td>
</tr>
<tr>
<td>34</td>
<td>LTC dispensing: 14 days – Pharmacy dispenses medication in 14-day supplies</td>
</tr>
<tr>
<td>35</td>
<td>LTC dispensing: 8-14 day dispensing not listed above – 8-14-day dispensing cycle not otherwise represented</td>
</tr>
<tr>
<td>36</td>
<td>LTC dispensing: dispensed outside of short cycle. Medicare Part D coverage was determined post dispensing</td>
</tr>
</tbody>
</table>

Refer to the NCPDP standard at [www.ncpdp.org/Members/Standards-Lookup.aspx](http://www.ncpdp.org/Members/Standards-Lookup.aspx). Membership to NCPDP is required to view this information online.

**10.07.04 LTC Days Supply Limitations**

As per CMS guidance, LTC Providers in the LTC Medicare Part D networks are only allowed to dispense up to a 31-day supply of medication for Part D Enrollees. In the event that a medication being provided is the smallest commercially available package size and exceeds the allowable 31-day supply, the quantity may be submitted utilizing the quantity of the single package with the corresponding day supply. Refer to section **10.07.03 LTC Billing** of the Provider Manual.

**10.07.05 LTC Transition Fill**

(Note: Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills must be submitted with the appropriate LTC Pharmacy Service Type and Patient Residence Codes. See additional information in the table below).
<table>
<thead>
<tr>
<th>Transition Fill Condition</th>
<th>Description</th>
<th>Allowed TF Supply</th>
</tr>
</thead>
</table>
| Part D Enrollee who is newly enrolled in Plan                                            | • Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period                                    | • Dispense drugs with a first fill of a maximum of an approved month’s supply, or less if the prescription is written for fewer days.  
• Prescriptions are allowed to have refills that accumulate to at least an approved month’s supply within at least the first 90 days of coverage in the new Plan. |
|                                                                                       | • Transition of newly eligible Part D Enrollee from other coverage                                                                        |                                                                                                                                |
|                                                                                       | • Transition of Part D Enrollee switching from one plan to another after start of contract year                                           |                                                                                                                                |
| Renewing Part D Enrollee across Plan contract years                                     | • Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within 180 days from date of claim and previous claim not TF  
• If Part D Enrollee has not transitioned before beginning of new Plan benefit year | • Dispense drugs with a first fill of a maximum of an approved month’s supply, or less if the prescription is written for fewer days.  
• Prescriptions are allowed to have refills that accumulate to at least an approved month’s supply within at least the first 90 days of coverage effective at the beginning of the new contract year. |
| “Part D Enrollee residing in LTC facility (New Patient Admission)”                       | LTC New Patient Admission/Level of Care Change within past 30 days                                                                       | • Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.  
• Dispense drugs with a first fill of a maximum of an approved month’s supply, or less if the prescription is written for fewer days. Multiple fills are allowed within 31 days of admission or change of care.  
• Submit SCC 420-DK Value “18”.  
• Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes.  
• If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance. |
<table>
<thead>
<tr>
<th>Transition Fill Condition</th>
<th>Description</th>
<th>Allowed TF Supply</th>
</tr>
</thead>
</table>
| "Part D Enrollee residing in LTC facility (Emergency Supply)" | LTC Emergency Supply | • Dispense a 14-day supply per fill (or less as written) for oral brand solid drugs.  
• Dispense drugs with a first fill of a maximum of 31-day supply, or less if the prescription is written for fewer days.  
• Submit SCC 420-DK Value "7".  
• Submit appropriate LTC Pharmacy Service Type and Patient Residence Codes.  
If situation falls outside of what defined above, contact the Pharmacy Help Desk for assistance. |
| Part D Enrollee requesting exception and decision still pending | Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days supply exhausted | Contact the Pharmacy Help Desk for overrides under this condition. |

*Refer to section 10.07.03 LTC Billing of the Provider Manual for exceptions.

### 10.07.06 Special Package Indicator

NCPDP has created an additional field for Special Package Indicator (SPI). Caremark does not require SPI Codes at this time, but will accept the values shown below if submitted. At such time Caremark requires SPI Codes, Caremark will provide Provider with written notice.

<table>
<thead>
<tr>
<th>NCPDP Field 429-DT</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>Not specified</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Not Unit Dose - product is not being dispensed in special unit dose packaging</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Manufacturer Unit Dose - a distinct dose as determined by the manufacturer</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Pharmacy Unit Dose - when the pharmacy has dispensed the drug in a unit-of-use package which was &quot;loaded&quot; at the pharmacy – not purchased from the manufacturer as a unit dose</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Pharmacy Unit Dose Patient Compliance Packaging - Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Pharmacy Multi-drug Patient Compliance Packaging - Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Remote Device Unit Dose - Drug is dispensed at the facility, via a remote device, in a unit-of-use package</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Remote Device Multi-drug Compliance - Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Manufacturer Unit-of-Use Package (not unit dose) – Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use. Applicable in LTC claims only (as defined in Telecommunication Editorial Document)</td>
</tr>
</tbody>
</table>
10.07.07 LTC Override Requests

Emergency Supply:

Note the following text from Chapter 6 of the Medicare Part D manual. The requirement states to allow a one-time emergency fill while an exception or prior authorization is being processed (after the 90-day transition period has expired) for up to 31 days of medication, unless the prescription is written for less than 31 days.

If the prescription in question was written for less than 31 days, it is within CMS guidelines to restrict to one fill. According to CMS regulations, standard prior authorization requests must be decisioned within 72 hours. Standard exception requests must be decisioned within 72 hours of receiving the Prescriber’s supporting statement.

Provider shall not apply Emergency Supply overrides to situations outside the defined scenario(s) that CMS describes in the Prescription Drug Benefit Manual below.

Chapter 6 of CMS Prescription Drug Benefit Manual states the following:

Section 30.4.6 - Emergency Supply for Current Enrollees in the LTC Setting
(Rev. 18, Issued: 01-15-16, Effective: 01-15-16; Implementation: 01-15-16)

Since, as a matter of general practice, LTC facility residents must receive their medications as ordered without delay, Part D sponsors must also cover emergency supplies of non-formulary Part D drugs for LTC facility residents after the transition period.

During the first ninety (90) days after enrollment, the Part D Enrollee will receive a transition supply as described in section 30.4. However, to the extent that a Part D Enrollee in an LTC setting is outside his or her 90-day transition period, the Plan Sponsor must still provide an emergency supply of non-formulary Part D drugs while an exception or prior authorization request is being processed. These emergency supplies of non-formulary Part D drugs must be for at least 31 days of medication, regardless of dispensing increments, unless the prescription is written by a Prescriber for less than 31 days. In cases where the smallest available marketed package size is not available for less than a 31-day supply, the Plan Sponsor must still provide an emergency supply when required. Part D Sponsors and their processors must determine how best to process claims in such cases. Multiple 14-day or less supplies can be supplied for brand name drugs to meet a minimum of a 31-day emergency supply requirement. A Plan Sponsor is not expected to provide more than a one-time 31-day emergency fill of a particular drug per LTC stay.

Section 30.4.7 - Level of Care Changes (excerpt)
(Rev. 10, Issued: 02-19-10, Effective/Implementation Date: 03-01-10)

In addition to circumstances impacting new Part D Enrollees who may enter a plan with a medication list that contains non-formulary Part D drugs, other circumstances exist in which unplanned transitions for current Part D Enrollees could arise and in which prescribed drug regimens may not be on sponsor formularies. These circumstances usually involve level of care changes in which a Part D Enrollee is changing from one treatment setting to another. For example, Part D Enrollees who enter LTC facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary with very short term planning taken into account (often under eight hours). Similar situations may exist, for example, for Part D Enrollees who are discharged from a hospital to a home; for Part D Enrollees who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; for Part D Enrollees who give up hospice status to revert to standard Medicare Part A and B benefits; for Part D Enrollees who end an LTC facility stay and return to the community; and for Part D Enrollees who are discharged from psychiatric hospitals with drug regimens that are highly individualized.
Below are Part D Plan Sponsor’s utilization management rules to LTC Part D Enrollees for LTC emergency supplies and LTC admissions/level of care changes.

1. An emergency supply must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days.
2. Transition supplies of non-formulary Part D drugs for LTC admission/level of care changes must be for at least 31 days of medication unless the prescription is written by a Prescriber for less than 31 days.
3. Provider must maintain documentation substantiating any SCC values or override codes transmitted on a Medicare Part D claim.

Emergency Supply Situations:
- **Emergency Kit Dispensing:** Emergency Kit/Box (E-Box) medications for emergency treatment until standard supply can be dispensed
- **First Fill Following Emergency Kit Dose:** Follow-up fill after emergency dose has been dispensed. This prescription should be filled for the fully prescribed amount minus the emergency dosing
- **LOA (Leave of Absence) Medications:** Separate dispensing of small quantities of medications for take-home use allowing Part D Enrollees to leave facility for weekend visits, holidays, etc.
- **Medication Spit Out:** Medication has been “spit out”
- **Emergency Supply:** Emergency supply of non-formulary drugs and formulary with PA or Step Therapy Requirements
- **LTC Admission/Level of Care Change:** Newly admitted due to clinical status change
  1. Medications may have:
     a. Been filled at retail pharmacy prior to admit;
     b. Been filled prior to transfer and discontinued;
     c. Not followed Part D Enrollee to new facility due to regulatory and compliance issues and same medications reordered upon re-admit
  2. New Admission/Level of Care Change:
     a. Valid within 31 days of New Admission/Level of Care change
     b. Up to 34-day supply with multiple fills
     c. Day Supply of 34 includes those claims where SCC 18 is not used

Qualified claims for LTC Emergency Supply and LTC New Patient Admission Transition Fills are submitted with the Pharmacy Service Type (PST) and Patient Residence (PR) that designate LTC (for RXBINs 004336, 012320 and 610591 only).

- For LTC Emergency Supply: Use SCC [NCPDP Field # 420-DK] Value “07”
- For LTC New Patient Admission/Level of Care Change: Use SCC NCPDP [Field # 420-DK] Value “18”

### 10.07.08 LTC Overrides for Current Part D Enrollees

<table>
<thead>
<tr>
<th>D.Ø NCPDP FIELD</th>
<th>D.Ø VALUE/CODE</th>
<th>SITUATION</th>
<th>ALLOWANCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCC 420-DK</td>
<td>16</td>
<td>Emergency Kit (Emergency Dose)</td>
<td>5-day supply</td>
</tr>
<tr>
<td>SCC 420-DK</td>
<td>17</td>
<td>First Fill Following Emergency Kit Dose</td>
<td>Written Rx Less E.R. Kit Dose given</td>
</tr>
<tr>
<td>SCC 420-DK</td>
<td>14 (use value 3 for ALF)</td>
<td>Leave of Absence (Vacation supply)</td>
<td>5-day supply</td>
</tr>
<tr>
<td>SCC 420-DK</td>
<td>15</td>
<td>Patient “Spit Out”</td>
<td>Not applicable</td>
</tr>
<tr>
<td>D.Ø NCPDP FIELD</td>
<td>D.Ø VALUE/CODE</td>
<td>SITUATION</td>
<td>ALLOWANCES</td>
</tr>
<tr>
<td>------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>SCC 420-DK</td>
<td>07</td>
<td>Emergency Supply (only as defined in this section)</td>
<td>31-day supply</td>
</tr>
<tr>
<td>SCC 420-DK</td>
<td>18</td>
<td>LTC Admission/ Level of Care Change</td>
<td>Up to 34-day supply with multiple fills within 31 days of admission or change of care, day supply includes claims where no SCC 18 is used after New Admission/Level of Care Change</td>
</tr>
<tr>
<td>SCC 420-DK</td>
<td>19</td>
<td>Partial Payment under Medicare Part A</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Refer to the NCPDP Payer Sheets at www.caremark.com/pharinfo.

10.07.09 Medicare Part A and Medicare Part D Drug Coverage Determinations

LTC Providers should consult their Caremark LTC Addendum regarding clarification on Medicare Part A and Medicare Part D drug coverage determinations.

Hospice care is a Medicare Part A benefit and, therefore, drugs provided by hospice and covered under the Medicare Part A payment to the hospice program are not covered under Part D. Only drugs which are used primarily for relief of pain and symptom control related to an individual’s terminal illness are covered by the hospice program. When a Medicare Part D claim rejects due to hospice validation, the claim will also reject with:

Reject 569 <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>>
Reject 75 <<Prior Authorization Required>>
Reject A3 <<This Product May Be Covered Under Hospice – Medicare A>>

In addition to the above rejects, secondary messaging is returned. The secondary message is as follows:

<<Hospice drugs not covered under Part D. If unrelated to terminal diagnosis, call XXX-XXX-XXXX>>.

The reject message will direct the pharmacy to the Pharmacy Help Desk. The Pharmacy Help Desk representative will verify if the Part D Enrollee is in hospice and inform Provider that written termination documentation from hospice or Part D Enrollee is required before an override can be placed.

IMPORTANT:

1. As specified in the Social Security Act, Section 1861(dd), and Federal Regulations (42 C.F.R. Section 418 et seq.), hospice programs must provide individuals under hospice care with drugs and biologicals related to the palliation and management of the terminal illness as defined in the hospice plan of care.
2. Stand-alone prescription drug Plan Sponsors cannot easily identify and prevent Part D payment for hospice drugs. Provider should work with LTC facilities in which their patients reside or hospice providers to identify any Part D Enrollees who have elected hospice care and ensure hospice drugs are not billed to Part D.
3. For those Plan Sponsors utilizing Caremark coverage determination services, if the treatment is unrelated to the terminal condition, the Pharmacy Help Desk will direct the Provider to ask the hospice provider to fax the form to the Coverage Determinations and Appeal Department and provide the written documentation for the Part D exception. Provider must provide the Pharmacy Help Desk with the hospice provider’s contact information to help expedite the process. Caremark’s Prior Authorization department will handle the documentation requests and inform Provider if an approval will be made.
4. For Part D Plan Sponsors not utilizing Caremark for coverage determinations, the telephone number in the message will direct Provider to the Part D Plan Sponsor’s coverage determination department to initiate the process.
5. Per CMS guidance, for Part D Enrollees and/or caregivers who state they are no longer in hospice, Caremark requires written documentation prior to overriding the hospice reject. The four acceptable forms are outlined...
The following valid documents can be provided as Best Available Evidence of hospice disenrollment or discharge:

1. Written statement from Part D Enrollee to hospice indicating date revocation is to be effective: Applies when Part D Enrollee has chosen to no longer continue with hospice benefits.
2. Notice of Medicare Non-Coverage (NOMNC): Hospice initiates discharge because Part D Enrollee is no longer considered terminally ill.
3. Discharge summary (provided by hospice to a facility or physician): Hospice discharged Part D Enrollee for cause, or because Part D Enrollee is no longer within the hospice service area.
4. NCPDP form: Submitted by hospice or physician indicating date of discharge.

10.08 Retail Addendum to the Caremark Provider Agreement

Terms of Participation in Medicare Part D

By entering into the Provider Agreement, Provider agrees to comply with the following terms (as noted in this Retail Addendum to the Caremark Provider Agreement) to the extent Provider provides Pharmacy Services to a Part D Enrollee and Provider is a Retail Pharmacy as that term is defined in 42 C.F.R. § 423.100. In the event any provision in this Retail Addendum to the Caremark Provider Agreement (“Retail Addendum”) conflicts with the terms of the Provider Agreement (including the Provider Manual), the terms of this Retail Addendum shall govern. Provider acknowledges that CVS Caremark Part D Services, L.L.C., together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, “Caremark” for the purposes of this Retail Addendum) are responsible for providing Part D services on behalf of Part D Plan Sponsors.

To the extent that Provider shall provide Pharmacy Services to a Part D Enrollee, Provider agrees to comply with any applicable Part D requirements for participation in Part D as a Dispensing Pharmacy.

Without limiting the generality of the foregoing, and notwithstanding anything in the Provider Agreement to the contrary, Provider agrees as follows:

1. Provider agrees to participate as, and perform the functions of, a Part D Retail Dispensing Pharmacy, including any reporting functions required to Part D Plan Sponsors, in accordance with the terms and conditions set forth in this Retail Addendum.
2. Provider agrees to perform its services under this Retail Addendum in a manner that is consistent with, and encompasses the services required to support Part D and in compliance with the contractual obligations of a Part D Plan Sponsor to CMS.
3. Provider agrees not to hold any Part D Enrollee liable for payment of any fees that are the responsibility of Caremark or a Part D Plan Sponsor.
4. Provider and Caremark agree that Provider is not required to accept Insurance Risk as a condition of participation as a Dispensing Pharmacy for Part D, and in the Medicare Part D Retail Network.
5. Provider agrees to comply with all applicable federal and state laws and regulations, CMS guidance or instructions relating to Part D, and any minimum standards for Provider practice established by the States in which Provider is licensed. Provider agrees to comply with all applicable state and federal privacy and security requirements, including the confidentiality and security requirements set forth in 42 C.F.R. § 423.136, the Privacy Rule, Security Rule, and Transactions Standards.
6. Provider agrees to make its books and records available in accordance with, and for the period required by 42 C.F.R. § 423.505(i)(2), which gives HHS, the Comptroller General, or their designees (collectively, “Government Parties”), the right to audit, evaluate, collect, and inspect any books, contracts, records, computers, or other electronic systems, including medical records, and documentation of Provider involving transactions related to CMS’ contract with a Part D Plan Sponsor (collectively, “Records”), and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor’s contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the ten (10) year retention period. In the case of a request by a Government Party for the direct disclosure by Provider to the Government Party of Records,
Provider shall (a) provide Caremark with prompt written notice of the Government Party’s request so that Caremark can object or intervene as it deems proper; (b) take all appropriate steps to protect the confidentiality of the Records, including labeling it “CONFIDENTIAL AND PROPRIETARY – FOIA EXEMPT” and attaching a statement provided by Caremark explaining the application to the Records of any Freedom of Information Act or other exemptions to disclosure; and (c) provide Caremark with the opportunity to review the Records that is subject to disclosure to the Government Party prior to Provider’s release of same to the Government Party. Provider also agrees to maintain records and provide access in accordance with 42 C.F.R. § 423.505(b)(10).

7. Provider agrees that, upon a Part D Plan Sponsor delegating any activity or responsibility to Caremark and Caremark in turn delegating that activity or responsibility to Provider pursuant to this Retail Addendum, that activity or responsibility may be revoked if CMS, the Part D Plan Sponsor, or Caremark determines that Provider has not performed satisfactorily. CMS, the Part D Plan Sponsor, or Caremark may also exercise any remedies available at Law or under the Provider Agreement in lieu of revocation. Further, Provider agrees that such activity or responsibility shall be in accordance with 42 C.F.R. § 423.505(i)(3).

8. Provider agrees that Caremark and any Part D Plan Sponsor (with respect to its Part D Enrollees only) each has the right to approve, suspend, or terminate the Agreement in their sole discretion at any time.

9. Provider agrees that Caremark and the Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis.

10. Provider agrees to provide Part D Enrollees with access to Negotiated Prices for Covered Part D Drugs as required by and in accordance with 42 C.F.R. § 423.104(g).

11. Provider agrees to submit Claims to Caremark’s real-time claims adjudication system.

12. Provider agrees that when it dispenses a Covered Part D Drug to a Part D Enrollee, it will inform such Part D Enrollee at the point of sale of the lowest-priced, generically-equivalent version of that Covered Part D Drug, if one exists for the Part D Enrollee’s prescription, as well as any associated differential in price in accordance with 42 C.F.R. § 423.132.

13. Provider agrees to implement a method for maintaining up-to-date Part D Enrollee information such as, but not limited to, demographic and allergy (drug) information, and such other information as CMS may require.

14. Provider agrees to implement such utilization management and quality assurance programs, including concurrent drug utilization review, generic substitution and/or therapeutic interchange programs, as Caremark may require, and as consistent with and in compliance with 42 C.F.R. § 423.153(b), (c) and (d). Provider agrees to offer patient counseling to Part D Enrollees, where appropriate and/or required by Law.

15. Provider agrees to fill a prescription for a 90-day supply of Covered Part D drugs for Part D Enrollees at the appropriate cost-sharing and Negotiated Price as communicated by Caremark to Provider through the real-time claims adjudication process, including that which applies to individuals qualifying for the low-income subsidy.

16. Provider agrees to charge/apply the correct cost-sharing amount, including that which applies to individuals qualifying for the low-income subsidy.

17. Part D Claims may be priced using the Provider Agreement, the Caremark Medicare Part D Retail Network, or other Caremark or Plan Sponsor specific network.

18. INTENTIONALLY BLANK

19. Provider acknowledges that it is not a mail order pharmacy and it is a “retail pharmacy” as defined in 42 C.F.R. § 423.100.

20. Entire Agreement. This Retail Addendum, the Provider Agreement, the Provider Manual, and the Medicare Network Enrollment form, and all other applicable enrollment forms, constitute the entire agreement between Provider and Caremark for the purposes of Provider’s participation as a Medicare Part D Network Provider, all of which are incorporated by this reference as if fully set forth herein and referred to collectively as the “Provider Agreement” or “Agreement”. Any prior agreements, promises, negotiations, or representations related to the terms of this Retail Addendum are terminated and of no force and effect. Provider’s non-compliance with any of the provisions of this Retail Addendum will be a breach of the Provider Agreement. All pricing terms are considered to be Caremark’s confidential and proprietary information and may not be shared with any third party without express written consent from Caremark.

21. The following terms and phrases, when capitalized and when used in this Retail Addendum, have the meanings
set forth below. All other capitalized terms and conditions shall have the meaning set forth in the Provider Agreement.

a. “Claims” means those claims processed through the Caremark online, real-time claims adjudication system.

b. “CMS” means the Centers for Medicare and Medicaid Services under the Department of Health and Human Services.

c. “Covered Part D Drug(s)” has the same meaning as that term as defined in 42 C.F.R. § 423.100.8.

d. “Dispensing Fee” has the same meaning as such term is defined in 42 C.F.R. § 423.100 which states that dispensing fee means costs that are incurred at the point of sale and pay for costs in excess of the ingredient cost of a Covered Part D Drug each time a Covered Part D Drug is dispensed, and includes only pharmacy costs associated with ensuring the possession of the appropriate Covered Part D Drug is transferred to a Part D Enrollee.

e. “HHS” means the Department of Health and Human Services.

f. “Insurance Risk” has the same meaning as such term as defined in 42 C.F.R. § 423.4.

g. “Medicare Part D Retail Network” means Claims priced for a Part D Enrollee pursuant to the Retail Addendum to the Caremark Provider Agreement entitled “Caremark Medicare Part D Retail Pharmacy Network.”

h. “Negotiated Prices” has the same meaning as such terms as defined 42 C.F.R. § 423.100.

i. “Part D” means Part D of Title XVIII of the Social Security Act, which establishes the Voluntary Prescription Drug Benefit Program under Medicare.

j. “Part D Enrollee” means an individual covered by a Part D Plan.

k. “Part D Plan” has the same meaning as such term as defined in § 423.4, but limited to those Part D Plans that have contracted with SilverScript, L.L.C. to use pharmacy providers that have contracted with Caremark to provide Pharmacy Services to Part D Enrollees.

l. “Part D Plan Sponsor” has the same meaning as such term as defined in 42 C.F.R. § 423.4, but limited to those Part D Plan Sponsors that offer Part D Plans.

m. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

n. “Security Rule” shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. parts 160, 162 and 164, subpart C. Notwithstanding anything to the contrary in the Agreement, any requirements related to the Security Rule shall be effective no earlier than the applicable Compliance Date for the Security Rule.

11. Medicare Advantage

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

To the extent Provider provides Pharmacy Services for an Eligible Person for a claim covered by a Plan Sponsor that is a Medicare Advantage plan, Provider must comply with the following terms, if applicable:

1. The Department of Health and Human Services, the Comptroller General or their designees have the right to audit, evaluate, collect, and inspect any pertinent information including books, contracts, computer or other electronic systems, including medical records, and documentation related to CMS’ contract with Plan Sponsor for a period of ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. 42 C.F.R. 422.504(i) (2)(i)-(ii) and (iv).

2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (a) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (b) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (c) maintaining the records and information in an accurate and timely manner, and (d) ensuring timely access by enrollees to the records and information that pertain to them, including 42 C.F.R. 422.118; 42 C.F.R. 422.504(a)(13).

3. Provider may not hold an Eligible Person liable for payment of fees that are the legal obligation of the Plan Sponsor to fulfill. Such provision will apply, but will not be limited to, insolvency of Caremark or Plan Sponsor, contract breach, and Provider billing. 42 C.F.R. 422.504(g)(1)(i); 422.504(i)(3)(i ); MMA Manual Chapter 11, Section 100.

4. Any services performed in accordance with a contract are consistent and comply with the Plan Sponsor’s contractual obligations to CMS. 42 C.F.R. 422.504(i)(3)(iii).

5. Provider will be paid in compliance with the requirements of 42 C.F.R. 422.520(b).

6. Caremark and Plan Sponsor may approve, suspend, or terminate the Agreement with respect to Provider’s provision of Pharmacy Services for a Medicare Advantage Plan Sponsor. 42 C.F.R. 422.504(i)(5).

7. Caremark and Plan Sponsor have the right to revoke the Provider Agreement with respect to delegated activities performed or to seek other remedies in lieu of termination as provided in the Provider Agreement if Caremark, CMS or the Plan Sponsor determines that Provider has not performed its obligations satisfactorily. Caremark and Plan Sponsor will monitor Provider’s performance hereunder on an ongoing basis. 42 C.F.R. 422.504(i)(4)(ii) and (iii).

8. Caremark and Plan Sponsor will review the credentials of medical professionals affiliated with Provider. Caremark and Plan Sponsor will also review and approve the credentialing process, including audits of the credentialing process on an ongoing basis. 42 C.F.R. 422.504(i)(4)(iv).

9. Provider must comply with applicable Medicare laws and regulations and CMS instructions, and to allow audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of ten (10) years. 42 C.F.R. 422.504(i)(4)(v) and MMA Manual, Chapter 11, Section 100.4.

10. Provider agrees that Caremark and Plan Sponsor oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations. MMA Manual, Chapter 11, Section 100.4.

11. Provider must not discriminate in the furnishing of benefits on the basis of any factor that is related to health status, including but not limited to: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (g) disability. 42 C.F.R. 422.110(a).

12. Provider must comply with the Plan Sponsor’s policies and procedures and written standards, which in accordance with 42 C.F.R. 422.112(a)(6) require:

a. Timely access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services are continuously monitored to ensure compliance and that Caremark and Plan Sponsor will take corrective action as necessary;
b. Compliance with the Plan Sponsor’s coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations; and

c. Provider consideration of beneficiary input into Provider’s proposed treatment plan.

13. Provider must ensure that its Pharmacy Services are available 24 hours a day, 7 days a week, when medically necessary. 42 C.F.R. 422.112(a)(7)(ii).

14. Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. 422.112(a)(8).

15. Provider must provide effective and continuous patient care and quality review, and maintain health records in accordance with standards established by the Plan Sponsor, taking into account professional standards and that there is appropriate and confidential exchange of information with other network providers. 42 C.F.R. 422.112(b)(4)(ii)-(iii).

16. Provider must establish procedures to ensure that Eligible Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and systems to address barriers to Eligible Person compliance. 42 C.F.R. 422.112(b)(5) and (6).

17. Nothing in the Agreement shall be construed as requiring Provider to indemnify Caremark or Plan Sponsor against any civil liability for damage caused to an Eligible Person as a result of a Plan Sponsor’s denial of medically necessary care to such Eligible Person. 42 C.F.R. 422.212.
12. Medicare-Medicaid Plan

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

A Medicare-Medicaid Plan (MMP), or dual demonstration plan, is a program administered by CMS and a particular state Medicaid agency that integrates the services provided by both the Medicare and Medicaid programs into one plan provided to eligible Medicare-Medicaid Eligible Persons.

12.01 Medicare-Medicaid Networks Standards

To the extent Provider provides Pharmacy Services to a Medicare-Medicaid Eligible Person, and without limiting any other provision in the Agreement, Provider must comply with CMS Medicare Part D requirements, including the components of the Three-Way contract between CMS, an individual state Medicaid agency, and a specific Plan Sponsor.

12.02 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicare-Medicaid Plan Eligible Person is made, in whole or in part, from federal funds, which subjects Provider to laws such as, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable state laws including minimum standards of pharmacy practice. Refer to section 16. Federal and State Laws and Regulations of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Caremark Pharmacy Portal, refer to section 1.06 Pharmacy Portal of the Provider Manual.
13. Qualified Health Plans

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

For Qualified Health Plan ("QHP") Eligible Persons eligible for health benefits under a QHP ("Eligible Person") offered by a QHP Issuer (as defined in 45 C.F.R. 155.20), or "Plan Sponsor", on the Federally-facilitated Exchange or a State Partnership Exchange, Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and the Department of Health and Human Services ("HHS") guidance, including but not limited to, 45 C.F.R. 156.340(a), to the extent relevant to the Pharmacy Services provided.

2. To permit access by HHS and the Office of Inspector General ("OIG"), or their designees, in connection with those entities’ right to evaluate through audit, inspection, or other means, to the downstream entity’s books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer’s obligations in accordance with 45 C.F.R. 156.340(a), until ten (10) years after the final date of the Provider Agreement period.

3. For purposes of clarity, delegated activities and reporting responsibilities as described in 45 C.F.R. 156.340(b), if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.

4. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.

5. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer or Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.

6. Caremark will monitor Provider’s performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

For QHP Eligible Persons eligible for health benefits under a QHP offered by a QHP Issuer on a State-based Exchange, including but not limited to, Arkansas, California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and guidance issued by HHS, a State-based Exchange or other applicable regulatory body, to the extent relevant to the Pharmacy Services provided.

2. To perform Pharmacy Services in a manner consistent with and in compliance with the QHP Issuer’s contractual obligations to the State-based Exchange or other applicable regulatory body.

3. To permit access by HHS, the OIG, the State-based Exchange or other applicable regulatory body, or their designees, in connection with those entities’ right to evaluate through audit, inspection, or other means, to the downstream entity’s books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer’s obligations until ten (10) years after the final date of the Provider Agreement period.

4. For purposes of clarity, delegated activities and reporting responsibilities, if any, are those Pharmacy Services specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.

5. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.

6. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer, State-based Exchange, applicable regulatory body, Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.

7. Caremark will monitor Provider’s performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

14.01 Advertising and Trademarks

Caremark, or its affiliates, retains exclusive rights to, and in, the names “CVS/caremark™” and “Caremark®” together with other distinctive trademarks or service marks that have been used by Caremark or may be adopted or used by Caremark in the future.

Provider must not advertise or use any name, symbol, trademark or service mark of Caremark or Plan Sponsor in advertising or any other promotional information other than as specifically permitted by the Provider Agreement without prior written consent of Caremark or Plan Sponsor respectively.

Caremark or Plan Sponsors may: (1) use the name, logos, address(es) of Provider in directories, informational brochures or other publications provided to Plan Sponsors or Eligible Persons; (2) use the information regarding Provider’s services that is provided to Caremark by Provider in publications provided to Plan Sponsors or Eligible Persons; and (3) provide Plan Sponsors or Eligible Persons with credentialing information.

Upon termination for any reason, Provider must immediately discontinue the use of any name, symbol, trademark or service mark of Caremark in advertising or any other promotional information.

14.02 Non-Disparagement

Provider may not place in a false light, disparage, defame, nor make any damaging, derogatory, or unfavorable public statements regarding Caremark, Caremark’s products, programs, services, employees, personnel, and brands. Provider will provide appropriate and adequate training to ensure compliance with these requirements. Provider’s obligations hereunder shall survive termination of the Agreement.

14.03 Confidentiality

“Confidential Caremark Information” is defined as any non-public information or data of Caremark and includes but is not limited to, (1) Caremark’s products, programs, services, designs, inventions, business practices, policies and procedures, customer list, information related to a Plan Sponsor, trade secrets; (2) MAC lists; (3) reimbursement rates and terms; (4) the Provider Agreement, the Provider Manual, network enrollment forms and other addenda, and other Caremark Documents; and (5) other information relating to Caremark’s business.

Provider must maintain in confidence and may not disclose, sell, assign, transfer, or give to any third party, including a Plan Sponsor or Eligible Person, Confidential Caremark Information without Caremark’s prior written consent. Provider may use Confidential Caremark Information only for the purpose of carrying out its obligations under the Provider Agreement. Provider may disclose Confidential Caremark Information to its employees, agents, consultants, or authorized representatives who have a need to know the Confidential Caremark Information in order to carry out Provider’s obligations under the Provider Agreement and who (1) have been informed of the confidential and proprietary nature of the Confidential Caremark Information, and (2) have agreed in writing not to disclose the Confidential Caremark Information to others and to treat the Confidential Caremark Information in accordance with the requirements of this section.

Provider agrees to protect the security of Confidential Caremark Information and to ensure that it is used and disclosed only as permitted herein. Provider must promptly notify Caremark if it becomes aware of any unauthorized use of Confidential Caremark Information. Provider is responsible to Caremark for any breach of this section by its employees, agents, consultants, or authorized representatives.

No Confidential Caremark Information may be quoted or attributed to Provider or Caremark without the prior written consent of Caremark.
Provider agrees to protect the confidentiality and security of an Eligible Person’s personal information (which includes any information that identifies or can be used to identify an Eligible Person), as required by applicable Law, and to use and disclose such information only as permitted by and in accordance with applicable Law.

This Confidentiality section applies to the extent consistent with applicable Law.

14.04 Non-Solicitation and Non-Interference

Provider must not (directly or indirectly): (1) communicate with any current Plan Sponsor about terminating its agreement with Caremark; (2) interfere with the relationship or potential relationship between Caremark and a Plan Sponsor or Eligible Person; (3) use or disclose Confidential Caremark Information for the purpose of soliciting a Plan Sponsor or Eligible Person, or for any other purpose not in furtherance of the Agreement; (4) communicate with a Plan Sponsor regarding Provider network participation status or network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor; (5) provide inaccurate plan benefit design information to an Eligible Person; or (6) communicate with any Plan Sponsor or potential Plan Sponsor about entering into an agreement for pharmacy benefit management services with any person other than Caremark.

Provider must not (directly or indirectly): (1) communicate with any Eligible Person or a Plan Sponsor’s group(s) about person or group terminating its agreement with the Plan Sponsor; (2) interfere with negotiations that a Plan Sponsor is conducting for the provision of health benefits, including pharmacy benefits, to Eligible Persons or groups; (3) use or disclose to any third party, Eligible Person or Plan Sponsor group information acquired during the term of the Agreement for the purpose of soliciting Eligible Persons or Plan Sponsor groups, or for any other purpose not in furtherance of the Agreement; or (4) communicate with a Plan Sponsor’s group regarding Provider’s network participation status or the network terms (including without limitation, reimbursement rates) as to a network that has been actively selected by the Plan Sponsor or group.

Nothing contained herein shall prevent Provider from disclosing any information required by Law to be disclosed or otherwise required to be disclosed to an Eligible Person in the fulfillment of the Provider’s professional responsibilities for an Eligible Person.

14.05 Proprietary Rights

Provider has no right to use, reproduce or adapt any information, data, work, compilation, computer program, manual, process or invention obtained from, provided by, or owned by Caremark or Plan Sponsor (including but not limited to, products, programs, services, business practices, procedures), without Caremark’s prior written consent.

Provider agrees that the information contained in the claims adjudication system that was obtained by and through the administration and adjudication of a claim by Provider is the property of Caremark, and Provider agrees not to claim any right, title, or interest in said information.

Caremark, and its affiliates, have the right to use, reproduce, and adapt any information or data obtained from Provider in any manner deemed appropriate, even if such use is outside the scope of the Provider Agreement, provided such use is in accordance with applicable Law.

14.06 Remedies

Provider acknowledges that any unauthorized disclosure or use of information or data obtained from or provided by Caremark would cause Caremark immediate and irreparable injury or loss that cannot be fully remedied by monetary damages.

Accordingly, if Provider should fail to abide by the provision and terms set forth in these sections of the Provider Manual (Intellectual Property, Confidentiality, and Proprietary Rights), Caremark will be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and judgment for damages (including reasonable attorneys’ fees and costs) caused by the breach, and all other remedies provided by the Provider Agreement and applicable Law.
15. Miscellaneous

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

15.01 Assignment

Neither party may assign the Agreement without the prior written consent of the other party; provided, however, that Caremark may, without consent, assign the Agreement to any direct or indirect parent, subsidiary, or affiliated company or to a successor company.

Any permitted assignee shall assume all obligations of its assignor under the Agreement. The Agreement shall inure to the benefit of and be binding upon each party, its respective successors and permitted assignees.

If Provider’s proposed assignment is approved by Caremark, Provider covenants that Provider shall enter into an agreement with such permitted successor or permitted assignee assigning Provider’s rights and obligations under the Agreement in form and substance acceptable to Caremark, including naming Caremark as an express third-party beneficiary thereof. Notwithstanding an approved assignment and a permitted successor’s or permitted assignee’s assumption of Provider’s liabilities and obligations under the Agreement, Provider will remain jointly liable for any liabilities and obligations under the Agreement until such permitted successor or permitted assignee satisfies such liabilities and obligations in full.

The terms of this Assignment section apply notwithstanding any other provision in the Agreement.

15.02 Independent Contractors and Third-Party Beneficiaries

Caremark and Provider are considered independent contractors, and shall have no other legal relationship under or in connection with the Provider Agreement. Neither party will act as or be deemed a representative of the other party for any reason whatsoever.

Except as otherwise provided for in the Provider Agreement, including but not limited to, the Indemnification section of the Provider Agreement and section 15.09 Arbitration of the Provider Manual, no term or provision in the Provider Agreement is for the benefit of any person who is not a party to the Provider Agreement, and no such party shall have any right or cause of action under the Provider Agreement.

15.03 Court Orders, Subpoenas or Governmental Requests

If Caremark receives a court order, subpoena or governmental request relating solely to Provider, Caremark may comply with such order, subpoena or request, and Provider must indemnify and hold harmless Caremark for, from, and against any and all costs (including reasonable attorneys’ fees and costs), losses, damages, or other expenses Caremark may suffer or incur in connection with the responding to such order, subpoena or request.

If Provider is requested or required to disclose any Confidential Caremark Information, whether by oral questions, interrogatories, requests for information or documents, subpoenas, or other processes, Provider must promptly provide Caremark with written notice of any such request or requirement so that Caremark may seek an appropriate protective order or other appropriate remedy. If such protective order or other remedy is not obtained, Provider will disclose only that portion of the Confidential Caremark Information as to which it has been advised by legal counsel that disclosure is required by Law; and Provider must exercise its best efforts to obtain reliable assurances that confidential treatment will be accorded to the Confidential Caremark Information that is disclosed in response to such requests or requirements.

15.04 Notices

A notice pursuant to the Provider Agreement to Caremark must be in writing, be delivered in person by certified mail, courier, or first class mail, and be addressed to Network Management at Caremark at the address below:

Caremark
Attn: Network Management, MC080
9501 East Shea Boulevard
Scottsdale, AZ 85260
Any notice to Caremark must also be addressed and delivered to:

Caremark  
Attn: General Counsel, MC035  
9501 East Shea Boulevard  
Scottsdale, AZ 85260

A notice pursuant to the Provider Agreement to Provider must be in writing, delivered in person by certified mail, courier, or first class mail, at the street, mailing, or check mailing address set forth in Provider’s enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark. Notwithstanding the foregoing, Caremark may give notice to Provider (1) via the claims adjudication system; (2) by facsimile via the Provider’s facsimile number, or by e-mail via the e-mail address provided by Provider in Provider’s enrollment documentation or as otherwise indicated by Provider to Caremark and agreed to by Caremark; or (3) via Caremark’s Pharmacy Portal.

Notices are deemed received on the date of delivery to the other party when delivered in person, by courier, by e-mail, by facsimile, by secure electronic message, by certified mail, or when posted via Caremark’s Pharmacy Portal. If notice is sent by first class mail, the notice is deemed received on the third business day after the date such notice was mailed.

By participating as a provider in Caremark’s networks, Provider acknowledges that it has a prior express business relationship with Caremark and consents to receive facsimile communications as well as automated messages from Caremark.

The terms of this Notices section apply notwithstanding any other provision in the Provider Agreement.

**15.05 Termination**

**15.05.01 Termination for Cause**

In the event Provider breaches the Provider Agreement, which includes the Provider Manual, addenda and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider’s participation in any Caremark network or Plan Sponsor network) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity. Refer to section 7. Compliance Reviews of the Provider Manual.

Caremark may immediately terminate the Provider Agreement if:

1. To the extent consistent with applicable Law, Provider makes an assignment for the benefit of creditors, files a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property or a proceeding is commenced against it which will substantially impair its ability to perform the Provider Agreement;

2. Any court, governmental, or regulatory agency issues to Provider an order to cease and desist from providing Pharmacy Services;

3. (a) There is any change in who holds (directly or indirectly) the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (b) The right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party;

4. A levy, writ of garnishment, attachment, execution or similar item is served upon Provider and not removed within ten (10) days from the date of service;

5. Caremark reasonably determines that Provider is no longer active;

6. If the Provider fails to satisfy amounts or other obligations owed to Caremark, certain remedies may apply, including termination of the Provider Agreement and any other available remedies;

7. Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which:
   a. Appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or general public;
   b. Implies a failure to maintain proper licensure and related requirements for licensure;
   c. Otherwise impairs Provider’s ability to fulfill the requirements of the Provider Agreement;
   d. Is a breach of the Agreement. Caremark’s ultimate remedies under this section include immediate termination of the Provider Agreement, including termination of pharmacies found to have a direct or indirect relationship with Provider or its affiliates based upon common officers, directors, current/former employees, owners (direct or indirect); or
e. Constitutes fraud, waste or abuse

The termination rights set forth in this section are in addition to any and all other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity. The effective date of a termination shall be determined by Caremark and as in accordance with applicable Law.

For any Provider with multiple locations, Caremark retains the right to terminate one or any number of Provider’s pharmacy locations without terminating the Provider Agreement.

15.05.02 Termination Without Cause

Unless precluded by applicable Law, Caremark may at any time terminate the Provider Agreement without cause or terminate Provider from providing Pharmacy Services to specific Plans without cause upon a notice to Provider, regardless of the network(s) in which Provider participates.

Unless precluded by applicable Law, Provider may terminate the Provider Agreement without cause upon one hundred fifty (150) days’ prior written notice to Caremark provided, however, that if applicable Law or a Caremark network or a Plan Sponsor network requires a longer notice period, the Provider Agreement shall not terminate until the expiration of such longer period.

Unless precluded by applicable Law, Provider may terminate participation in any Caremark network or a Plan Sponsor network upon one hundred fifty (150) days’ prior written notice to Caremark, specifying the date of termination and the names of the Caremark network(s) or Plan Sponsor network(s) in which Provider will no longer participate, provided, however, that if applicable Law or a Caremark network or Plan Sponsor network requires a longer notice period, the termination will not take effect until the expiration of such longer period. Absent the prior written consent of Caremark, Provider may not elect to participate in a Caremark network or a Plan Sponsor network, for thirty (30) days or until the next solicitation period for that Caremark network or Plan Sponsor network, whichever is longer, to the extent consistent with applicable Law.

The terms of this Termination Without Cause section apply notwithstanding any other provision in the Provider Agreement. For termination without cause by Provider from a Medicare Part D network, refer to section 10.01.01 Network Participation of the Provider Manual.

15.05.03 Rights and Remedies in the Event of Termination or Breach

In the event of a termination of the Provider Agreement for any reason, Provider must (upon Caremark’s request) surrender the Provider Agreement, Provider Manual, other Caremark Documents, other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider’s possession or control.

In the event Provider breaches any provision of the Provider Agreement, in addition to all other termination rights, Caremark shall have the right, to the extent not contrary to Law, to (1) suspend any and all obligations of Caremark, including payment to Provider, under and in connection with the Provider Agreement, (2) impose reasonable handling, investigation and/or improper use fees, and/or (3) in whole or in part, offset against any amounts owed to Provider under the Provider Agreement or under any other agreement between Caremark and Provider, any amounts required to be paid by Provider to Caremark. These rights and remedies are not exclusive and are in addition to any other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

15.06 Survival of Certain Provisions

Termination of the Provider Agreement or Caremark or Plan Sponsor network will have no effect upon the rights and obligations of the parties accruing prior to the effective date of termination.

15.07 Amendments

From time to time, and notwithstanding any other provision in the Provider Agreement (which includes the Provider Manual), Caremark may amend the Provider Agreement, including the Provider Manual or other Caremark Documents, by giving notice to Provider of the terms of the amendment and specifying the date the amendment becomes effective. If Provider submits claims to Caremark after the effective date of any notice or amendment, the terms of the notice or amendment is accepted by Provider and is considered part of the Provider Agreement.
15.08 Enforceability

In the event that any provision or term set forth in the Provider Agreement is determined invalid or unenforceable, such invalidity and unenforceability will not affect the validity or enforceability of any other provision or term set forth in the Provider Agreement.

15.09 Arbitration

Any and all disputes between Provider and Caremark [including Caremark’s current, future, or former employees, parents, subsidiaries, affiliates, agents and assigns (collectively referred to in this Arbitration section as “Caremark”)], including but not limited to, disputes in connection with, arising out of, or relating in any way to, the Provider Agreement or to Provider’s participation in one or more Caremark networks or exclusion from any Caremark networks, will be exclusively settled by arbitration. This arbitration provision applies to any dispute arising from events that occurred before, on or after the effective date of this Provider Manual. Any dispute otherwise arbitrable hereunder shall be deemed waived, and no such dispute shall be made or raised, unless a Dispute Notice has been given to Caremark, or arbitration filed, as provided below. Unless otherwise agreed to in writing by the parties, the arbitration shall be administered by the American Arbitration Association (“AAA”) pursuant to the then applicable AAA Commercial Arbitration Rules and Mediation Procedures including the rule governing Emergency Measures of Protection (available from the AAA). In no event may the arbitrator(s) award indirect, consequential, or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, injury to reputation, or loss of customers or business, except as required by Law.

The arbitrator(s) shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of the agreement to arbitrate, including but not limited to, any claim that all or part of the agreement to arbitrate is void or voidable for any reason. In the event the arbitrator(s) determine that any provision of this agreement to arbitrate is invalid for any reason, such provision shall be stricken and all remaining provisions will remain in full force and effect. The arbitrator(s) must follow the rule of Law, and the award of the arbitrator(s) will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. Any such arbitration must be conducted in Scottsdale, Arizona and Provider agrees to such jurisdiction, unless otherwise agreed to by the parties in writing.

Discovery shall be limited to documents and information for which there is a direct, substantial, and demonstrable need and where such documents and information can be located and produced at a cost that is reasonable in the context of all surrounding facts and circumstances. Further, when the cost and burden of e-discovery are disproportionate to the likely importance of the requested materials, the arbitrator may deny the requests or require that the requesting party advance the reasonable cost of production to the other side. Absent a showing of exceptional circumstances, as determined by the arbitrator(s), the parties shall be limited to one corporate representative deposition per party with each deposition subject to a four-hour time limit. The expenses of arbitration, including reasonable attorney’s fees, will be paid for by the party against whom the final award of the arbitrator(s) is rendered, except as otherwise required by Law.

Arbitration with respect to a dispute is binding and neither Provider nor Caremark will have the right to litigate that dispute through a court. In arbitration, Provider and Caremark will not have the rights that are provided in court, including the right to a trial by judge or jury. In addition, the right to discovery and the right to appeal are limited or eliminated by arbitration. All of these rights are waived and disputes must be resolved through arbitration. None of these rights are rights of any party to any future dispute.

No dispute between Provider and Caremark may be pursued or resolved as part of a class action, private attorney general or other representative action or proceeding (hereafter all included in the term “Class Action”). All disputes are subject to arbitration on an individual basis, not on a class or representative basis, or through any form of consolidated proceedings, and the arbitrator(s) will not resolve Class Action disputes and will not consolidate arbitration proceedings without the express written permission of all parties to the Provider Agreement. Provider and Caremark agree that each may pursue or resolve a dispute against the other only in its individual capacity, and not as a plaintiff or class member in any purported Class Action.

Except as may be required by Law, a party, its employees, agents, consultants, authorized representatives, counsel, or arbitrator(s) shall not disclose the existence, content or results of any dispute or arbitration hereunder without the prior written consent of both parties. In the event a Provider is required by law to make such a disclosure, Provider shall notify Caremark five (5) business days in advance of such disclosure. Provider acknowledges and agrees that any breach of this provision would cause Caremark immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if Provider, its agents, counsel or arbitrator fail to abide by the terms and conditions set forth in this Section 15.09 of the Provider Manual, Caremark shall be entitled to (i) specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Agreement, and to judgment for damages (including reasonable attorneys’ fees and costs) caused by the breach; (ii) an option to void the dispute resolution or arbitration award; and (iii) to all other legal and equitable remedies available to Caremark.
Prior to a party initiating an arbitration, such party shall request in writing to the other party ("Dispute Notice") a meeting of authorized representatives of the parties for the purpose of resolving the dispute. Disputes must be filed within the following timeframes: (i) for audit related disputes, within six (6) months from the date of the final audit findings; (ii) for termination related disputes, within six (6) months from the date of the notification of termination; and (iii) for all other disputes, within six (6) months from the date on which the facts giving rise to the dispute first arose. The parties agree that, within fourteen (14) business days after issuance of the Dispute Notice, each party shall designate a representative to participate in dispute resolution discussions which will be held at a mutually acceptable time and place (or by telephone) for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner. If despite the good faith efforts of the parties, the authorized representatives of the parties are unable to resolve the dispute within forty-five (45) business days after the issuance of the Dispute Notice, or if the parties fail to meet within such forty-five (45) business days, either party may, by written notice to the other party, submit the dispute to binding arbitration provided however that any demand for arbitration must be filed within six (6) months from the date of the issuance of the Dispute Notice. The above notwithstanding, nothing in this provision shall prevent either party from utilizing the AAA’s procedures for emergency relief to seek preliminary injunctive relief to halt or prevent a breach of this Provider Agreement.

Any party initiating an arbitration pursuant to this arbitration section shall place in escrow for the benefit of the opposing party an amount to be determined by the arbitrator(s) as sufficient to cover the estimated attorney’s fees and other expenses of arbitration that will be incurred in defense of the arbitration action, which shall in no event be less than $50,000. Such funds will be released upon the entry of a final award of the arbitrator(s), with any excess reimbursed to the initiating party. Failure to place such funds in escrow will constitute a material breach of this arbitration section.

The terms of this arbitration section apply notwithstanding any other or contrary provision in the Provider Agreement, including but not limited to, any contrary language in any Third Party Beneficiary provision. This Arbitration section survives the termination of the Provider Agreement and the completion of the business relationship between Provider and Caremark. This arbitration agreement is made pursuant to a transaction involving interstate commerce, and shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

15.10 Force Majeure

Caremark and Provider are excused from performance under the Provider Agreement to the extent that either Caremark or Provider is prevented from performing all or any part of the Provider Agreement as a result of causes that are beyond the affected party’s reasonable control, including but not limited to, fire, flood, earthquakes, tornadoes, other acts of God, war, work strikes, civil disturbances, power or communications failure, court order, government intervention, a change in Law, a significant change in the industry, or third-party nonperformance.

15.11 Anti-Kickback Statute, Stark Law, and Caremark Compliance Program

Each party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C § 1320a-7b(b) ("Anti-Kickback Statute"), or the federal “Stark Law,” set forth at 42 U.S.C § 1395nn (“Stark Law”), with respect to the performance of its obligations under this Provider Agreement. In addition, Caremark’s Code of Conduct and policies and procedures on the Anti-Kickback Statute and Stark Law may be accessed at www.caremark.com/pharminfo.

15.12 Rebate Programs

Caremark has the right to submit all prescriptions relating to the Provider Agreement to pharmaceutical companies in connection with Caremark’s rebate programs and any similar programs. Provider must not submit any of the prescriptions relating to the Provider Agreement to any pharmaceutical company for the purpose of receiving any rebate, discount or the like, except as authorized by Caremark in writing.

15.13 Eligible Person Communications

Provider understands and acknowledges that Caremark may communicate with Eligible Persons as required by Plan Sponsor, applicable Law, or as Caremark determines is necessary regarding matters such as plan benefits, network design and composition, formulary and clinical issues, and manufacturer recalls.
16. Federal and State Laws and Regulations

In the event Provider breaches any terms and conditions outlined in this section of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider’s participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

16.01 Compliance with Laws

Notwithstanding anything in the Agreement to the contrary, Provider must comply with all applicable Laws (including any implementing regulations) in performing its Pharmacy Services under the Agreement, included but not limited to: the False Claims Act (31 U.S.C. 3729 et seq.); the Anti-kickback statute (42 U.S.C. 1320a-7b(b); Stark Law (42 U.S.C. 1395 nn); Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) (45 C.F.R. Parts 160, 162, and 164), and the Controlled Substance Act (21 U.S.C. 801-971); and Caremark must comply with all applicable Laws (including any implementing regulations) in performing its duties under the Agreement, provided however that in the event that Provider alleges that Caremark has not complied with an applicable Law, Provider shall not be entitled to a private right of action unless expressly permitted under the underlying applicable Law, and Provider shall not be entitled to any contract damages or other contract remedies against Caremark other than as specified by such underlying applicable Law.

Federal and state specific addenda, as updated from time to time to reflect regulatory changes, are set forth in the Caremark Pharmacy Portal at www.rxservices.cvscaremark.com and are incorporated herein by reference. Refer to section 1.06 Pharmacy Portal of the Provider Manual.
Appendix A - Caremark Payer Specification Sheets

The Caremark Payer Specification Sheets and NCPDP Version D.0 Payer Sheets can be found at www.caremark.com/pharminfo. Please carefully review the appropriate Payer Sheet(s) since the submission of certain optional data elements in the current NCPDP Version may be required by Plan Sponsors and must be submitted for processing.
Appendix B - Reject Codes

A list of reject codes can be found at www.caremark.com/pharminfo.

Providers can also refer to the NCPDP standard at www.ncpdp.org/Members/Standards-Lookup.aspx. Membership to NCPDP is required to view this information online.

In addition, Providers can contact their software vendor to learn more about submission reject codes.
Appendix C
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Appendix D - Drug Submission Requirements

Note: This section contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with Caremark.

OPHTHALMIC PRODUCTS

Ophthalmic Drops (solutions and suspensions)

Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists. Acute therapy may be submitted for Prescriber-specified days (e.g., ciprofloxacin eye drops for 5 days – enter 5 days supply). Information in the chart below is based on total drops per day being utilized in the prescribed directions and the bottle size being dispensed.

<table>
<thead>
<tr>
<th>Total Drops Per Day</th>
<th>2.5 mL</th>
<th>5 mL</th>
<th>10 mL</th>
<th>15 mL</th>
<th>20 mL</th>
<th>30 mL</th>
<th>40 mL</th>
<th>45mL</th>
</tr>
</thead>
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<tr>
<td>One</td>
<td>37 (30/34 acceptable)</td>
<td>75</td>
<td>150</td>
<td>225</td>
<td>300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>18</td>
<td>37 (30/34 acceptable)</td>
<td>75</td>
<td>112 (90/100 acceptable)</td>
<td>150</td>
<td>225</td>
<td>300</td>
<td>337</td>
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<tr>
<td>Three</td>
<td>12</td>
<td>25</td>
<td>50</td>
<td>75</td>
<td>100 (90 acceptable)</td>
<td>150</td>
<td>200</td>
<td>225</td>
</tr>
<tr>
<td>Four</td>
<td>9</td>
<td>18 (30/34 acceptable)</td>
<td>56</td>
<td>75</td>
<td>112 (90/100 acceptable)</td>
<td>150</td>
<td>168</td>
<td></td>
</tr>
<tr>
<td>Six</td>
<td>6</td>
<td>12</td>
<td>25</td>
<td>37 (30/34 acceptable)</td>
<td>50</td>
<td>75</td>
<td>100 (90 acceptable)</td>
<td>112 (90/100 acceptable)</td>
</tr>
<tr>
<td>Eight</td>
<td>4</td>
<td>9</td>
<td>18</td>
<td>28 (30/34 acceptable)</td>
<td>56</td>
<td>75</td>
<td>84</td>
<td></td>
</tr>
</tbody>
</table>

Ophthalmic Ointments

Eye ointments are typically dispensed as one package per prescription. It is rare for Prescribers to write for more than one tube per prescription. Should a prescription be presented for multiple packages or for quantity unavailable, the pharmacy staff should clarify the prescribed quantity and directions for use to support the prescription and day supply entered on the claim.

Ophthalmic Single-Use Vials

Single-Use vial ophthalmics should be calculated based on directions for use and the dosage units available within the single dose vial and packaging. Note: Single dose vials are commonly used in both eyes during a single dosage application.

<table>
<thead>
<tr>
<th>NDC</th>
<th>How Supplied</th>
<th>Common Dosage</th>
<th>Common Day Supply</th>
<th>Common Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>00023-9163-30</td>
<td>30 single-use vials/package</td>
<td>1 drop 2 times daily in each eye</td>
<td>60 for a 30-day supply</td>
<td>Commonly misbilled as 120 for 30 days. Single-use vial can be utilized for both eyes.</td>
</tr>
</tbody>
</table>
## Proper Billing for Oral Inhalers

Refer to section 4, Claims Submission of the Provider Manual for a list of claim submission requirements.

### Oral Inhaler Chart

<table>
<thead>
<tr>
<th>Inhaler Name</th>
<th>Billing Pkg Size</th>
<th>Total Inhalations Per Box</th>
<th>Manufacturer Recommended Adult Max Daily Dose</th>
<th>Product Expiration Once Opened</th>
<th>TOTAL # of Inhalations Used Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Advair® Diskus 100/50 mcg, 250/50 mcg, 500/50 mcg</td>
<td>60 ea 60</td>
<td>2</td>
<td>1 month</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Advair® HFA 45/21 mcg, 115/21 mcg, 230/21 mcg</td>
<td>12 gm 120</td>
<td>4</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Alvesco® 80 mcg</td>
<td>6.1 gm 60</td>
<td>8</td>
<td>N/A</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Alvesco® 160 mcg</td>
<td>6.1 gm 60</td>
<td>4</td>
<td>N/A</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Arnity® Ellipta® 100 mcg</td>
<td>30 ea 30</td>
<td>2</td>
<td>6 weeks</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Arnity® Ellipta® 200 mcg</td>
<td>30 ea 30</td>
<td>1</td>
<td>6 weeks</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Asmanex® Twisterhale 220 mcg</td>
<td>1 ea 30</td>
<td>4</td>
<td>45 days</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Asmanex® Twisterhale 220 mcg</td>
<td>1 ea 120</td>
<td>4</td>
<td>45 days</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Asmanex® HFA 110 mcg, 200 mcg</td>
<td>13 gm 120</td>
<td>4</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Atovent® HFA 17 mcg</td>
<td>12.9 gm 200</td>
<td>12</td>
<td>N/A</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td>Bevespi Aerosphere® 9 mcg/4.8 mcg</td>
<td>10.7 gm 120</td>
<td>4</td>
<td>3 months</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Breo® Ellipta® 100/25 mcg, 200/25 mcg</td>
<td>60 ea 30</td>
<td>1</td>
<td>6 weeks</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Combivent® Respimat® 20/100 mcg</td>
<td>4 gm 120</td>
<td>6</td>
<td>3 months</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Dulera® 100/5mcg, 200/5 mcg</td>
<td>13 gm 120</td>
<td>4</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Flovent® Diskus 100 mcg</td>
<td>60 ea 60</td>
<td>20</td>
<td>2 months</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Flovent® Diskus 250 mcg</td>
<td>60 ea 60</td>
<td>8</td>
<td>2 months</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Flovent® HFA 44 mcg</td>
<td>10.6 gm 120</td>
<td>20</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Flovent® HFA 110 mcg, 220 mcg</td>
<td>12 gm 120</td>
<td>8</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>ProAir® HFA 90 mcg</td>
<td>8.5 gm 200</td>
<td>12</td>
<td>N/A</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td>ProAir® RespiClick 90 mcg</td>
<td>1 ea 200</td>
<td>12</td>
<td>N/A</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td>Proventil® HFA 90 mcg</td>
<td>6.7 gm 200</td>
<td>12</td>
<td>N/A</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® 90 mcg</td>
<td>1 ea 60</td>
<td>16</td>
<td>N/A</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® 180 mcg</td>
<td>1 ea 120</td>
<td>8</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>QVAR RediHaler™ 40 mcg</td>
<td>10.6 gm 120</td>
<td>16</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>QVAR RediHaler™ 80 mcg</td>
<td>10.6 gm 120</td>
<td>8</td>
<td>N/A</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Seebr™ Neohaler® 15.6 mcg</td>
<td>60 ea 60</td>
<td>2</td>
<td>N/A</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Seretide® Diskus® 50 mcg</td>
<td>60 ea 60</td>
<td>2</td>
<td>6 weeks</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Spiriva® Handihaler® 18 mcg</td>
<td>30 ea 30</td>
<td>1</td>
<td>Once Opened</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Spiriva® Respimat® 1.25 mcg, 2.5 mcg</td>
<td>4 gm 60</td>
<td>2</td>
<td>3 months</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Wixela™ Inhub™ 100/50 mcg, 250/50 mcg, 500/50 mcg</td>
<td>60 ea 60</td>
<td>2</td>
<td>1 month</td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>
PROPER BILLING FOR NASAL SPRAYS

Refer to section 4. Claims Submission of the Provider Manual for a list of claim submission requirements.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Billing Package Size</th>
<th>Total Sprays per Box</th>
<th>Manufacturer Recommended Adult Max Daily Dose</th>
<th>Product Expiration Once Opened</th>
<th>TOTAL # of Sprays Used Per Day</th>
<th>Days' Supply</th>
<th>( ) Indicates Acceptable Days' Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astepro® (azelastine) 0.15%</td>
<td>30 mL</td>
<td>200</td>
<td>8</td>
<td>N/A</td>
<td>200</td>
<td>100 (90)</td>
<td>50</td>
</tr>
<tr>
<td>azelastine 0.1%</td>
<td>30 mL</td>
<td>200</td>
<td>8</td>
<td>N/A</td>
<td>200</td>
<td>100 (90)</td>
<td>50</td>
</tr>
<tr>
<td>Beconase® AQ 42 mcg</td>
<td>25 gm</td>
<td>180</td>
<td>8</td>
<td>N/A</td>
<td>180</td>
<td>90</td>
<td>45</td>
</tr>
<tr>
<td>DDAVP™ (desmopressin) 0.01%</td>
<td>5 mL</td>
<td>50</td>
<td>4</td>
<td>N/A</td>
<td>50</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Dymista™ 137 mcg/50 mcg</td>
<td>23 gm</td>
<td>120</td>
<td>4</td>
<td>N/A</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Flonase® (fluticasone) 50 mcg</td>
<td>16 gm</td>
<td>120</td>
<td>4</td>
<td>N/A</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Flonase® Sensimist 27.5 mcg</td>
<td>15.8 mL</td>
<td>120</td>
<td>4</td>
<td>N/A</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>flunisolide 0.025%</td>
<td>25 mL</td>
<td>200</td>
<td>16</td>
<td>N/A</td>
<td>200</td>
<td>100 (90)</td>
<td>50</td>
</tr>
<tr>
<td>ipratropium bromide 0.03%</td>
<td>30 mL</td>
<td>345</td>
<td>12</td>
<td>N/A</td>
<td>345</td>
<td>172</td>
<td>86</td>
</tr>
<tr>
<td>ipratropium bromide 0.06%</td>
<td>15 mL</td>
<td>165</td>
<td>16</td>
<td>N/A</td>
<td>165</td>
<td>82</td>
<td>41</td>
</tr>
<tr>
<td>Lazanda® 100 mcg, 300 mcg, 400 mcg</td>
<td>1 ea</td>
<td>8</td>
<td>4</td>
<td>60 days</td>
<td>8</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Miacalcin® (calcitonin/salmon) 200 unit</td>
<td>3.7 mL</td>
<td>30</td>
<td>1</td>
<td>35 days</td>
<td>30</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Narcan® 4 mg/0.1 mL</td>
<td>2 ea</td>
<td>2</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Nasacort® Allergy 24HR (triamcinolone) 55 mcg</td>
<td>16.9 mL</td>
<td>120</td>
<td>4</td>
<td>N/A</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Nasalcrom® (cromolyn) 5.2 mg</td>
<td>26 mL</td>
<td>200</td>
<td>12</td>
<td>N/A</td>
<td>200</td>
<td>100 (90)</td>
<td>50</td>
</tr>
<tr>
<td>Nasonex® (mometasone) 50 mcg</td>
<td>17 gm</td>
<td>120</td>
<td>4</td>
<td>N/A</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Omnaris® 50 mcg</td>
<td>12.5 gm</td>
<td>120</td>
<td>4</td>
<td>4 months</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Onas™ 80 mcg</td>
<td>8.7 gm</td>
<td>120</td>
<td>4</td>
<td>N/A</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Patanase® (olopatadine) 665 mcg</td>
<td>30.5 gm</td>
<td>240</td>
<td>8</td>
<td>N/A</td>
<td>240</td>
<td>120</td>
<td>60</td>
</tr>
<tr>
<td>Rhinocort Aqua™ (budesonide) 32 mcg</td>
<td>8.6 gm</td>
<td>120</td>
<td>8</td>
<td>N/A</td>
<td>120</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Sprix® 15.75 mg/act.</td>
<td>5 ea</td>
<td>40</td>
<td>4</td>
<td>24 hours</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Stimate™ (desmopressin) 1.5 mg/mL</td>
<td>2.5 mL</td>
<td>25</td>
<td>2</td>
<td>6 months</td>
<td>25</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Zetonna™ 37 mcg</td>
<td>6.1 gm</td>
<td>60</td>
<td>2</td>
<td>N/A</td>
<td>60</td>
<td>30</td>
<td>-</td>
</tr>
</tbody>
</table>
# Appendix D
## Proper Billing for Common Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Transmit Quantity</th>
<th>Common Directions</th>
<th>Common Day Supply</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Tablets/Capsules</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benicar®, Crestor® (Rosuvastatin), Diovan®, Januvia®, Lipitor® (Atorvastatin), Pravachol® (Pravastatin), Singulair® (Montelukast), Synthroid® (Levothyroxine), Tricor® (Fenofibrate), Zetia®</td>
<td>Bill as 1 = one tablet/capsule</td>
<td>One tablet/capsule daily</td>
<td>30 tablets/capsules = 30-day supply</td>
<td>Commonly billed for incorrect day supply (e.g., 1 tablet daily billed for 90 tablets for a 30-day supply).</td>
</tr>
<tr>
<td>Boniva® (Ibandronate)</td>
<td>Bill as 1 = one tablet</td>
<td>One tablet every month</td>
<td>One tablet = 28-day supply</td>
<td>Commonly billed for incorrect quantity and day supply (e.g. more than one tablet in 28 days).</td>
</tr>
<tr>
<td>Cialis® 2.5 mg and 5 mg</td>
<td>Bill as 1 = one tablet</td>
<td>One tablet every day</td>
<td>30 tablets = 30-day supply</td>
<td>Commonly billed for incorrect strength (e.g. as needed versus for daily use).</td>
</tr>
<tr>
<td>Contraceptives (various) 28-day</td>
<td>Bill as 28 = one pack</td>
<td>One active tablet daily for twenty one days followed by seven days of inactive tablets</td>
<td>28 tablets = 28-day supply</td>
<td>Commonly billed for incorrect quantity (e.g. 84 for a 28-day supply instead of 28 for a 28-day supply).</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>Bill as 1 = one tablet</td>
<td>2.5 mg tablets, various quantities, typically dosed weekly</td>
<td>Varies</td>
<td>Commonly misfilled for incorrect directions.</td>
</tr>
<tr>
<td><strong>Oral Suspensions/Solutions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MiraLax®TM Packets (Polyethylene Glycol 3350)</td>
<td>Bill as 1 = one packet</td>
<td>One packet (17 gm) per day</td>
<td>30 packets = 30-day supply</td>
<td>Commonly billed for incorrect billing unit (e.g., grams instead of number of packets).</td>
</tr>
<tr>
<td>Moviprep® Powder for Solution</td>
<td>Bill as 1 = one box</td>
<td>Mix with water and drink as directed prior to procedure</td>
<td>One box = 1 or 2-day supply</td>
<td>Commonly billed for incorrect billing unit (e.g. milliliters instead of per box).</td>
</tr>
<tr>
<td><strong>Rectal/Vaginal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estrace® Cream</td>
<td>Bill as 42.5 grams = one tube</td>
<td>Titration therapy with maintenance of 1 application weekly</td>
<td>One 42.5 gram tube = 30-day supply</td>
<td>Commonly incorrectly billed for greater than one tube per month (confirm dosage for therapy, include titration if needed, and document).</td>
</tr>
<tr>
<td>Estring®</td>
<td>Bill as 1 = one ring</td>
<td>One ring every 84 days</td>
<td>One ring = 84-day supply</td>
<td>Commonly incorrectly billed as more than one ring. Attempt to bill for correct day supply before reduction to max day supply allowed by Plan.</td>
</tr>
<tr>
<td>Metronidazole gel 0.75%</td>
<td>Bill per gm</td>
<td>One applicatorful (approximately 5 gm) once or twice a day for five days</td>
<td>70 gm = 7-day supply</td>
<td>Commonly billed for incorrect quantity and day supply (e.g. applications are reusable).</td>
</tr>
<tr>
<td>NuvaRing®</td>
<td>Bill as 1 = one ring</td>
<td>Use one ring for 3 weeks, remove for 1 week</td>
<td>One ring = 28-day supply</td>
<td>Box of 3 can be split. Commonly incorrectly billed as 3 for 28 days.</td>
</tr>
<tr>
<td>Premarin® Cream</td>
<td>Bill per gm</td>
<td>0.5 – 2 gm per day depending on therapy</td>
<td>One 30 gram tube = 30-day supply</td>
<td>Commonly incorrectly billed for greater than one tube per month (confirm dosage for therapy, include titration if needed, and document).</td>
</tr>
<tr>
<td>Vagifem®</td>
<td>Bill as 1 = one tablet</td>
<td>10 mcg tablets, one tablet daily for 2 weeks then taper to maintenance dose of one tablet twice weekly</td>
<td>14 tablets = 14-day supply for starter dose 8 tablets = 28-day supply for maintenance</td>
<td>Commonly billed for incorrect quantity and day supply (e.g., refill contains starter dose quantity).</td>
</tr>
<tr>
<td>DRUG NAME</td>
<td>TRANSMIT QUANTITY</td>
<td>COMMON DIRECTIONS</td>
<td>COMMON DAY SUPPLY</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Medical Devices/Testing Supplies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freestyle Libre 14 Day Reader</td>
<td>Bill as 1 = one reader</td>
<td>Varies</td>
<td>Varies</td>
<td>Commonly incorrectly billed for more than one reader. One reader is good for up to 3 years per manufacturer.</td>
</tr>
<tr>
<td>Glucometers (all manufacturers)</td>
<td>Bill as 1 = one meter</td>
<td>Varies</td>
<td>Varies</td>
<td>Commonly incorrectly billed for more than one meter.</td>
</tr>
<tr>
<td>Pen Needles and Syringes (all manufacturers)</td>
<td>Bill as 1 = one needle/syringe</td>
<td>Varies</td>
<td>Varies</td>
<td>Commonly billed for incorrect quantity (e.g. billed for more than one box without documented utilization).</td>
</tr>
<tr>
<td><strong>Topical Preparations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acanya® (Clindamycin/Benzoyl), Carac® (Fluorouracil), Differin® (Adapalene) Cream, Epiduo®, Mirvaso®</td>
<td>Bill per gm</td>
<td>Apply once daily</td>
<td>Varies based on application area(s)</td>
<td>Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization). Also, incorrect package size billed.</td>
</tr>
<tr>
<td>Aczone®, Azelaíx®, Finacea®, Temovate® (Clobetasol) cream/ointment</td>
<td>Bill per gm</td>
<td>Apply twice daily</td>
<td>Varies based on application area(s)</td>
<td>Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization).</td>
</tr>
<tr>
<td>Aldara® (Imiquimod)</td>
<td>Bill per packet</td>
<td>Apply up to 2 packets each night for 2 weeks, followed by 2 weeks off</td>
<td>Varies based on application area(s)</td>
<td>Commonly billed for incorrect quantity (e.g., billed for more than one box without documented utilization).</td>
</tr>
<tr>
<td>Denavir®</td>
<td>Bill per gm</td>
<td>Apply every 2 hours while awake for 4 days within 1 hour of onset of symptoms</td>
<td>Varies based on application area(s)</td>
<td>Commonly billed for incorrect quantity (e.g., billed for more than one tube without documented utilization).</td>
</tr>
<tr>
<td>Jublia®</td>
<td>Bill per mL</td>
<td>Apply once daily to affected toenail(s)</td>
<td>Varies based on application area(s)</td>
<td>Commonly incorrectly billed for more than one bottle without the affected toenail(s) documented.</td>
</tr>
<tr>
<td>Picato®</td>
<td>Bill as 2 = one box (2 tubes of 0.05% gel) Or Bill as 3 = one box (3 tubes of 0.015% gel)</td>
<td>Apply one tube daily. Use 0.05% gel for 2 consecutive days on trunk/extremities Use 0.015% gel for 3 consecutive days on face/scalp</td>
<td>2 (0.05% gel) = 2-day supply 3 (0.015% gel) = 3-day supply</td>
<td>Commonly billed incorrectly for more than 2- or 3-day supply or for multiple boxes. Also, incorrect strength is selected for area of application indicated by physician.</td>
</tr>
<tr>
<td>Zovirax® (Acyclovir) cream/ointment</td>
<td>Bill per gm</td>
<td>Apply every 3 hours, 6 times a day to adequately cover all lesions of affected area(s) for 7 days</td>
<td>Varies based on application area(s)</td>
<td>Commonly billed for incorrect quantity and day supply (e.g. billed for more than one tube without documented utilization).</td>
</tr>
<tr>
<td><strong>Transdermal Systems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vivelle-Dot® (Estradiol)</td>
<td>Bill as 1 = one patch</td>
<td>One patch twice weekly</td>
<td>8 patches = 28-day supply</td>
<td>Commonly billed for incorrect quantity and day supply (e.g. greater than 2 patches per week).</td>
</tr>
<tr>
<td>Xulane®</td>
<td>Bill as 3 = one box (three patches)</td>
<td>One patch once per week for three weeks, remove for one week</td>
<td>3 patches = 28-day supply</td>
<td>Commonly billed for incorrect quantity and day supply (e.g. greater than one box per month).</td>
</tr>
<tr>
<td><strong>Injectables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avonex® pen kit</td>
<td>Based on NDC Bill as 1 = one kit (4 syringes) Or Bill as 1 = one syringe</td>
<td>Inject 30 mcg once a week</td>
<td>Based on NDC 1 kit (4 syringes) = 28-day supply Or 4 syringes = 28-day supply</td>
<td>Commonly billed for incorrect billing unit (e.g. number of syringes instead of per kit).</td>
</tr>
</tbody>
</table>
## Appendix D

### Proper Billing for Common Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Transmit Quantity</th>
<th>Common Directions</th>
<th>Common Day Supply</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enbrel® multiple-use vial (verify NDC)</td>
<td>Bill as 4 = four dose trays</td>
<td>One injection twice weekly</td>
<td>8 dose trays = 28-day supply</td>
<td>Commonly billed for incorrect NDC (e.g., Enbrel® single-use syringe instead of Enbrel® multiple-use vial).</td>
</tr>
<tr>
<td>Enbrel® single-use prefilled syringe</td>
<td>Bill per mL</td>
<td>One injection twice weekly</td>
<td>4.08 mL (box of four, 25 mg syringes) = 28-day supply 3.92 mL (box of four, 50 mg syringes) = 28-day supply</td>
<td>Commonly billed for incorrect billing unit (e.g., as number of syringes instead of mL) and/or billed for incorrect NDC (Enbrel® multiple-use vial instead of Enbrel® single-use syringe.)</td>
</tr>
<tr>
<td>Humira® Pen</td>
<td>Bill as 1 = one dose tray</td>
<td>Starter dose varies depending on indication One injection every other week (maintenance)</td>
<td>Varies depending on indication 2 (dose trays) = 28-day supply</td>
<td>Commonly billed for incorrect day supply (e.g., refill contains starter dose quantity).</td>
</tr>
<tr>
<td>Immitrex® (Sumatriptan)</td>
<td>Bill per mL</td>
<td>One injection, may repeat at least 1 hour later, maximum of 2 (6 mg) injections per 24 hours</td>
<td>Varies</td>
<td>Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL).</td>
</tr>
<tr>
<td>Lovenox® (Enoxaparin)</td>
<td>Bill per mL</td>
<td>One injection one or twice daily</td>
<td>Varies</td>
<td>Commonly billed for incorrect billing unit (e.g., as number of syringes or total mg dose instead of mL).</td>
</tr>
<tr>
<td>Prolia®</td>
<td>Bill per mL</td>
<td>One injection every 6 months</td>
<td>1 mL = 180-day supply</td>
<td>Commonly billed for incorrect day supply.</td>
</tr>
<tr>
<td>Saxenda®</td>
<td>Bill per mL</td>
<td>Initial dose = 0.6 mg per day for one week, increase dose at weekly intervals until 3 mg Maintenance dose = 3 mg daily</td>
<td>15 mL = 30-day supply</td>
<td>Commonly billed for incorrect quantity for day supply (e.g. 45 mL for a 30-day supply).</td>
</tr>
<tr>
<td>Stelara®</td>
<td>Bill per mL</td>
<td>Initial dose = one injection at week zero, repeat dose at 4 weeks Maintenance dose = one injection, every 12 weeks starting at week 16</td>
<td>1 mL or 2 mL (depending on strength) = 28-day supply 0.5 mL or 1 mL (depending on strength) = 84-day supply</td>
<td>Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL) and billed with incorrect day supply for quantity dispensed.</td>
</tr>
<tr>
<td>Trulicity®</td>
<td>Bill per mL</td>
<td>One injection weekly</td>
<td>2 mL = 28-day supply</td>
<td>Commonly billed for incorrect billing unit (e.g., number of syringes instead of mL).</td>
</tr>
<tr>
<td>Victoza®</td>
<td>Bill per mL</td>
<td>0.6 mg per day, 1.2 mg per day, or 1.8 mg per day</td>
<td>6 mL = 30-day supply (for 1.2 mg dose) 9 mL = 30-day supply (for 1.8 mg dose)</td>
<td>Commonly billed for incorrect billing unit (e.g. billed as milligrams instead of milliliters).</td>
</tr>
</tbody>
</table>

### Nasal Sprays

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Transmit Quantity</th>
<th>Common Directions</th>
<th>Common Day Supply</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azelastine</td>
<td>Bill per mL</td>
<td>One to two sprays per nostril twice daily</td>
<td>30 mL = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply.</td>
</tr>
<tr>
<td>Dymista®</td>
<td>Bill per gm</td>
<td>One spray per nostril twice daily</td>
<td>23 gm = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply.</td>
</tr>
<tr>
<td>Flonase® (Fluticasone)</td>
<td>Bill per gm</td>
<td>One to two sprays per nostril once daily</td>
<td>16 gm = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply.</td>
</tr>
<tr>
<td>Miacalcin® (Calcitonin- Salmon)</td>
<td>Bill per mL</td>
<td>One activation in one nostril once daily</td>
<td>3.7 mL = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply.</td>
</tr>
<tr>
<td>Nasonex® (Mometasone)</td>
<td>Bill per gm</td>
<td>Two sprays per nostril once or twice daily</td>
<td>17 gm = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply.</td>
</tr>
</tbody>
</table>
## PROPER BILLING FOR COMMON MEDICATIONS

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>TRANSMIT QUANTITY</th>
<th>COMMON DIRECTIONS</th>
<th>COMMON DAY SUPPLY</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Inhalers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flovent® HFA 44 mcg</td>
<td>Bill per gm</td>
<td>Two inhalations twice daily</td>
<td>10.6 gm = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply.</td>
</tr>
<tr>
<td>Flovent® HFA 110 mcg, 220 mcg</td>
<td></td>
<td></td>
<td>12 gm = 30-day supply</td>
<td></td>
</tr>
<tr>
<td>Spiriva Handihaler®</td>
<td>Bill per capsule</td>
<td>Two inhalations (one capsule) once daily</td>
<td>30 ea = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply. Also, incorrect NDC is chosen (e.g. Respimat versus Handihaler).</td>
</tr>
<tr>
<td>Spiriva Respimat®</td>
<td>Bill per gm</td>
<td>Two inhalations once daily</td>
<td>4 gm = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply. Also, incorrect NDC is chosen (e.g. Handihaler versus Respimat).</td>
</tr>
<tr>
<td>Tudorza Pressair®</td>
<td>Bill as 1 = one inhaler</td>
<td>One inhalation twice daily</td>
<td>1 ea = 30-day supply</td>
<td>Commonly billed for incorrect quantity and day supply (e.g. number of inhalations).</td>
</tr>
<tr>
<td><strong>Kits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chantix® Starter Pack</td>
<td>Bill as 53 = one pack</td>
<td>Initial = 0.5 mg once daily on days one through three, 0.5 mg twice daily on days four through seven, then 1 mg twice daily</td>
<td>53 tablets (one pack) = 28-day supply</td>
<td>Commonly billed for incorrect quantity and day supply. Also, starter pack is refilled without appropriate documentation.</td>
</tr>
<tr>
<td>Chantix® Continuing Pack</td>
<td>Bill as 56 = one pack</td>
<td>Maintenance = 1 mg twice daily for twelve weeks</td>
<td>56 tablets (one pack) = 28-day supply</td>
<td></td>
</tr>
<tr>
<td>Gattex Kit® (verify NDC)</td>
<td>Bill as 1 = one box (one vial)</td>
<td>Inject 0.05 mg/kg once daily</td>
<td>1 box (one vial) = 1-day supply</td>
<td>Commonly billed for incorrect quantity (e.g. vial versus box).</td>
</tr>
<tr>
<td></td>
<td>Bill as 1 = one box (30 vials)</td>
<td></td>
<td>1 box (30 vials) = 30-day supply</td>
<td></td>
</tr>
<tr>
<td>Rowasa® (Mesalamine) (verify NDC)</td>
<td>Bill as 1 = one box</td>
<td>One enema (4 gm) once daily</td>
<td>1 box (seven bottles) = 7-day supply</td>
<td>Commonly billed for incorrect quantity (e.g. number of bottles or milliliters).</td>
</tr>
<tr>
<td><strong>Eye Drops</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restasis® single-use vials</td>
<td>Bill per vial</td>
<td>One drop in both eyes twice daily</td>
<td>60 vials = 30-day supply</td>
<td>Commonly misbilled as 120 vials for a 30-day supply. Single-use vial can be utilized in both eyes.</td>
</tr>
<tr>
<td>Xiidra® single-use vials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restasis® Multi-dose™</td>
<td>Bill per mL</td>
<td>One drop in both eyes twice daily</td>
<td>5.5 mL = 30-day supply</td>
<td>Commonly misbilled for incorrect quantity and day supply.</td>
</tr>
<tr>
<td>Zioptan® single-use vials</td>
<td>Bill per vial</td>
<td>One drop in affected eye(s) once daily</td>
<td>30 vials = 30-day supply</td>
<td>Commonly misbilled as 120 vials for a 30-day supply. Single-use vial can be utilized in both eyes.</td>
</tr>
</tbody>
</table>
Appendix E - Diverse Retail Pharmacy Program

Frequently Asked Questions and Supplier Diversity Profile Form

What is the Caremark Diverse Retail Pharmacy Program?
The Diverse Retail Pharmacy Program is a component of the Caremark Supplier Diversity Initiative. The pharmacy program was formed in 2004 to encourage diverse-owned, independent retail pharmacies to become certified diverse business enterprises in order to expand and establish potential business opportunities with Caremark. Through this program, Caremark actively seeks to establish business relationships with diverse-owned retail pharmacies that want to sustain and grow their businesses.

Why was the Supplier Diversity Initiative developed?
The initiative complements the Caremark commitment to sound business practices and social responsibility to the communities we serve, recognizes the critical role diverse-owned businesses play in our continued success, and provides outstanding service and solutions to our customers and clients. Caremark corporate culture encourages support of the program to help ensure that all diverse businesses are given a fair opportunity to do business with us.

How can my pharmacy become part of the Caremark Diverse Retail Pharmacy Program?
You must:
- Be contracted with Caremark as an independent retail pharmacy;
- Be certified as a diverse business enterprise by a government or third-party entity; and
- Apply for the program by completing and submitting a Caremark supplier profile form.

What are the potential benefits of being certified, contracted and part of the program?
As a certified diverse business enterprise enrolled in the Diverse Retail Pharmacy Program, your business will receive:
- Recognition as a diverse business enterprise
- Access to targeted, set-aside federal government programs that ensure that a percentage of business is specifically directed to diverse business enterprises
- Expanded opportunities to sustain and grow your business
- Consideration for participation in Caremark contracts with clients
- Access to capital financing for business development and growth through governmental programs
- Opportunities to secure business with other organizations and other prescription benefit management (PBM) organizations seeking to do business with diverse suppliers
- Access to diverse supplier organizations and networks across the United States

What does it mean to be a certified diverse business enterprise?
It means that your pharmacy will be identified as a diverse owned and operated business entity according to federal classifications. This certification will give your pharmacy access to specially designated government or private programs that can provide you with financial assistance to help sustain, grow and develop your pharmacy business.

What if my pharmacy is not a certified diverse business enterprise? Will it affect my current relationship with Caremark?
If you are currently a contracted Caremark retail pharmacy but are not certified, it will not change your existing relationship with Caremark. However, if you would like to participate in the Caremark Diverse Retail Pharmacy Program your pharmacy will need to become certified.

What if my pharmacy is not contracted with Caremark?
If you would like to participate in the Caremark Diverse Retail Pharmacy Program, your pharmacy will need to become contracted with Caremark as an independently owned pharmacy.
Is it difficult to become certified or contracted, or apply for the program?
No. It is not difficult to become certified and contracted, or apply for the Caremark program, and Caremark can help.

How long does the contracting process take?
The process to become a contracted pharmacy with Caremark can be completed within six (6) to eight (8) weeks.

How long does the certification process take?
Typically the certification process requires sixty (60) to ninety (90) days for completion.

How long does the diverse retail pharmacy application process take?
The process takes approximately two (2) weeks. Caremark needs to verify and confirm the information that is provided and enter your pharmacy into our database. Once that has been completed, your pharmacy will be evaluated for immediate inclusion in contracts with our clients.

Are there any costs or fees involved in the certification process?
Yes. Certification by a third-party entity cost is based on your company revenue, along with an annual renewal fee. Certification by a government entity may involve a small fee and in some cases at no cost.

Are there any fees involved in contracting with Caremark as an independent retail pharmacy?
Yes. There is a one-time application fee. Please contact the Retail Pharmacy Department of Caremark for more information at www.caremark.com/pharminfo - “Pharmacy Enrollment Self Service”.

Are there any fees involved in applying for the program?
There are no membership fees, dues or other costs associated with applying for and becoming part of the Diverse Retail Pharmacy Program.

How do I know which certification is right for my pharmacy?
Determining which certification to seek depends on your business needs and requirements, where you are located, and where and how you want to grow your business. We suggest that you carefully review the benefits provided by the respective certifying entities.

- Certification with a third-party entity:
  - A certification fee and a yearly renewal fee
  - Inclusion in a national network of diverse-owned businesses
  - Access to grants, private small business administration loans and financial assistance nationwide
  - Opportunities for inclusion in Caremark contracts that utilize diverse suppliers
  - Access to targeted state/local government business opportunities
  - Recognition by government agencies

- Certification with a government entity:
  - Minimal or no fees
  - Access to state/local governmental business opportunities
  - Recognition by government agencies
  - Access to grants, private business administration loans and financial assistance nationwide
  - Opportunities for inclusion in Caremark contracts that use diverse suppliers

What type of certification does my pharmacy need to be eligible for the program?
Pharmacies can be certified with one or more entities, depending on your business needs and qualifications. Caremark recognizes, encourages and affords opportunities to the following types of certified diverse business enterprises:

- 8(a) Business Enterprises (8(a))
Appendix E

- Disabled Business Enterprises (DBEs)
- Disabled Veteran Business Enterprises (DVBEs)
- Disadvantaged Business Enterprises (DBEs)
- Historically Underutilized Business Zones (HUBZs)
- Lesbian, Gay, Bisexual and/or Transgender owned Business Enterprises (LGBTBEs)
- Minority Business Enterprises (MBEs)
- Women Business Enterprises (WBEs)
- Veteran Business Enterprises (VBEs)
- Disability Owned Business Enterprises (DOBE)

Who are the recognized Certifying organizations?
- Women Business Enterprises National Council (WBENC)
- National Minority Supplier Development Council (NMSDC)
- National Gay and Lesbian Chamber of Commerce (NGLCC)
- National Veteran Business Development Council (NVBDC)
- National Association of Veteran Owned Businesses (NaVOBA)
- U.S. Pan Asian American Chamber of Commerce (USPAACC)
- U.S. Hispanic Chamber of Commerce (USHCC)
- U.S. Business Leadership Network (USBLN)
- Small Business Association (SBA)
- Various State and Government Agencies

If my pharmacies are located throughout the United States, what kind of certification should I obtain?
You should consider obtaining national certification through a third-party entity for your pharmacies. You could also obtain government certification by the resident state or city of each pharmacy.

Where can I obtain the diverse business enterprise certification form?
You can obtain the form by directly contacting the certifying entity.

Where can I obtain the Caremark contracting and program application forms?
Refer to section 2. Credentialing and Quality Management of the Provider Manual for information regarding enrollment. You can obtain a program application form by contacting the Caremark Supplier Diversity Department at 1-855-287-2694

Does Caremark offer assistance with completing and submitting certification, contracting and application forms?
Because certification requirements vary for each certifying entity, Caremark is not able to assist you with that process. We recommend that you contact the entity directly so their staff can assist you with your specific business needs and requirements. However, Caremark can assist you with completing and submitting the Caremark contracting forms (to become an independent retail pharmacy) and supplier profile form.

How will I know when my pharmacy becomes certified?
You will receive notice of certification directly from the government or third-party entity to which you applied.

How will I know when my pharmacy contract is approved with Caremark?
You will be directly contacted and notified by the Caremark Retail Pharmacy Department.

As part of the program is my pharmacy guaranteed business opportunities with Caremark?
Caremark strives to provide opportunities to all qualified suppliers. Participation in the program does not entitle or guarantee business opportunities with Caremark. This process was designed to create and promote fair and equal opportunities for all.
As part of the program will I need to renew my pharmacy’s status or reapply to remain a Caremark supplier?

Once contracted and part of the program, your pharmacy will not need to reapply with Caremark. You will, however, need to reapply yearly for certification with the government or third-party entity to which you originally applied.

Once I receive certification as a diverse business enterprise and become contracted as an independent retail pharmacy with Caremark, where do I submit the supplier profile form?

Your completed supplier profile form should be accompanied by a copy of your:

- Current certificates/letters of certification
- Sales catalog or company brochure
- Product profile
- Capability statement

Please e-mail these documents to: supplierdiversity@cvshealth.com or create your profile online at cvshealth.myconxion.com/user/login.

How many diverse-owned retail pharmacies is part of the Caremark network?

There are more than 130 certified, diverse-owned independent retail pharmacies in the Caremark network throughout the United States.

How much money does Caremark spend with diverse-owned pharmacies?

Caremark spent approximately $225 million with diverse-owned independent retail pharmacies. By becoming a certified diverse business enterprise and filling out the supplier profile form, your pharmacy can become one of them.

What is unique about the Caremark Diverse Retail Pharmacy Program?

Caremark was one of the first companies in the PBM industry to develop a diverse retail pharmacy program and has a staff dedicated to supporting this important initiative. Our Supplier Diversity Initiative has shown nearly a 20% increase in spend with diverse suppliers yearly and works diligently to develop opportunities for diverse suppliers seeking to provide services that Caremark needs.

What else should I know about Caremark?

Caremark is the largest provider of prescriptions and related health services in the nation. We fill or manage more than one billion prescriptions annually. Through our unmatched breadth of service offerings, Caremark is helping to transform the delivery of health care services in the United States. We are uniquely positioned to effectively help manage costs and improve health care outcomes. To learn more, visit www.cvshealth.com.

Supplier Profile Form

Visit our website at cvshealthsupplierdiversity.com
Appendix F - New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts

(Revised April 1, 2017)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter “the Agreement” or “this Agreement”) the Article 44 plans and Providers that contract with such plans, and who are a party agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO contracts with Providers, and Providers must agree to such clauses.

A. Definitions for Purposes of this Appendix

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer a comprehensive health services plan, or a health and long-term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment. Under these arrangements, such health care Providers and suppliers will provide their service in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of Health Care Services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms and Conditions

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH, effective sixty (60) days subsequent to notice, subject to Public Health Law § 4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH, as may be required by the Medicaid Managed Care contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (a) an IPA/ACO, (b) an institutional network Provider, or (c) a medical group Provider that serves five percent (5%) or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (a) an institutional Provider or (b) a medical group Provider that serves five percent (5%) or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO’s Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish.
to meet general or specific obligations placed on the MCO by statute, regulation, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:

a. quality improvement/management;
b. utilization management, including but not limited to, precertification procedures, referral process or protocols, and reporting of clinical encounter data;
c. member grievances; and
d. Provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees, and shall require its Providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide twenty-four (24) hour coverage and back-up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA/ACO that is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO’s or IPA/ACO’s own acts or omissions, by indemnification or otherwise, to a Provider.


9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:

a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider’s or IPA/ACO’s performance does not satisfy the standards set forth in the Medicaid Managed Care contract.

b. The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider’s or IPA/ACO’s performance.

c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.

d. The MCO and the Provider or IPA/ACO agree that a woman’s enrollment in the MCO’s Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid Managed Care or the MCO does not offer a Medicaid Managed Care product in the mother’s county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
f. The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of any Member of Congress in connection with the award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying," Appendix attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LF-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

h. The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee’s involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).

i. The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).

j. The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information.

k. The Provider or IPA/ACO agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than $25,000 during the 12–month period ending on the date of the request made by DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within thirty-five (35) days of such request.

l. The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG’s website, within five (5) days of executing this agreement, stating that:

i. The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

ii. All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.

iii. Payment requests are submitted in accordance with applicable law.
m. The Provider or IPA/ACO agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG’s website, before the subcontractor requests payment under the subcontract, acknowledging that:

i. The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

ii. All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.

iii. Payment requests are submitted in accordance with applicable law.

10. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA’s Providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27–F of the Public Health Law, and Mental Hygiene Law § 33.13.

12. Compliance Program. The Provider agrees that if it claims, orders, or is paid $500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363–d(2) and 18 NYCRR § 521.3.

13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within thirty (30) days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363–d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG’s website.

C. Payment and Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a Managed Long-Term Care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person, provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee’s liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable
efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third-party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA/ACO must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406–c(5–c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology, or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (Provider, IPA/ACO, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided within the required timeframes and under the circumstances described in Public Health Law §4903.

6. The parties agree to follow Section 3224–a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.

7. The parties agree to follow Section 3224–b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association’s Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services® Healthcare Common Procedure Coding System (HCPCS).

8. The parties agree to follow Section 3224–b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a health care Provider, except where: (a) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (b) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six (6) years from date payment was received by the health care Provider with written notice thirty (30) days prior to engaging in overpayment recovery efforts. Such notice must state the patient’s name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.
9. The parties agree to follow Section 3224-c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.

10. The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization was required and received from the appropriate person or entity prior to the rendering of the service.

11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:
   a. Provide for the MCO’s ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
   b. Include a provision to address circumstance where the Provider’s financial condition indicates an inability to continue accepting such risk; and
   c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
   d. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.

12. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:
   a. The parties expressly agree to amend or terminate the contract at the direction of DOH (applies to Tier 1, Tier 2, and Tier 3);
   b. The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO’s progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and
   c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and
   d. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO’s enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement (applies to Tier 2 and Tier 3).

D. Records and Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee’s medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to, newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee’s medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable)
expressly acknowledges that the Provider shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid reimbursable services, the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA/ACO, institutional network Provider, or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA/ACO and an institutional Provider or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than forty-five (45) days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than forty-five (45) days’ notice provided the MCO demonstrates to the satisfaction of DOH, prior to termination, that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional sixty (60) days’ notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO’s Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACOs Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO’s enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA/ACO insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term “Provider” shall include the IPA/ACO and
the IPA/ACO’s contracted Providers if this Agreement is between the MCO and an IPA/ACO. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation and copies of all decisions.


1. Any reference to IPA/ACO Quality Assurance (QA) activities within this Agreement is limited to the IPA/ACO’s analysis of utilization patterns and quality of care on its own behalf and as a service to its contractual Providers.
Appendix F-1 - Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of this Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: 

TITLE:

PHARMACY; ORGANIZATION:

PHARMACY NCPDP/NPI:

NAME: (PLEASE PRINT)

SIGNATURE:

*** Please FAX the completed Appendix F-1 page back to Caremark Network Services at 1-866-316-4336. ***
Appendix F-2 - Standard Clauses for Managed Care Provider/IPA Contracts for the Fully-Integrated Duals Advantage Program

January 1, 2015

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions for Purposes of This Appendix

“Managed Care Organization” or “MCO” shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

“Independent Practice Association” or “IPA” shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. “IPA” may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

“Provider” shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms and Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent (5%) or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent (5%) or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA’s providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:
   - quality improvement/management;
   - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
   - member grievances; and
   - provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO’s or IPA’s own acts or omissions, by indemnification or otherwise, to a provider.


9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:
   a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider’s or IPA’s performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;
   b. The Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider’s or IPA’s performance; and
   c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.
   d. The MCO and the Provider or IPA agree that a woman’s enrollment in the MCO’s Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid
managed care product in the mother’s county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the “Certification Regarding Lobbying,” Appendix F-1 attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL “Disclosure Form to Report Lobbying,” in accordance with its instructions.

h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person’s involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs).

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

l. The Provider agrees to have an officer, director or partner of the Provider execute and deliver to SDOH a certification, using a form provided by SDOH through OMIG’s website, within 5 days of executing this agreement, stating that:

i. the Provider is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of SDOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO;

ii. that all claims for care, services or medical supplies for which the provider submits for payment have been provided; and

iii. that payment requests are submitted in accordance with applicable law.
m. The Provider agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by SDOH through OMIG’s website, before the subcontractor requests payment under the subcontract, acknowledging that:

i. the subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of SDOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO;

ii. that all claims for care, services or medical supplies for which the subcontractor submits for payment have been provided; and

iii. that payment requests are submitted in accordance with applicable law.

10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA’s providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law § 33.13.

12. Compliance Program. The Provider agrees that if it claims, orders, or is paid $500,000.00 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.

13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, that it shall certify to the SDOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR § 521.3 and Social Services Law § 363-d(2) is in place, and shall recertify during the month of December each year thereafter using a form provided by OMIG on its website.

C. Payment/Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, non-payment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-
service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee’s liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member’s inpatient hospital discharge, consistent with Public Health Law § 4903.

D. Records Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee’s medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent (5%) or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH’s satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than nonrenewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA’s Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA’s providers agree, that the IPA providers shall continue to provide care to the MCO’s enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term “provider” shall include the IPA and the IPA’s contracted providers if this Agreement is between the MCO and an IPA. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services
to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.
Appendix G - CMS Form No. 10147 (English)

OMB Approval No. 0938-0975

Enrollee’s Name (Optional):

Drugs and Prescription Number (Optional):

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

Your Medicare rights

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

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

What you need to do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan's toll-free phone number on the back of your plan membership card, or by going to your plan's website. You or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

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

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

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

Form CMS-10147
Appendix G1 - CMS Form No. 10147 (Spanish)

Número de OMB 0938-0975
Nombre del beneficiario (opcional):

Número de receta y de medicamento (opcional):

LA COBERTURA DE MEDICARE DE LAS RECETAS MÉDICAS Y SUS DERECHOS

Sus derechos si tiene Medicare

Usted tiene el derecho de solicitar una determinación de cobertura de su plan Medicare de recetas médicas si está en desacuerdo con la información proporcionada por la farmacia. También tiene el derecho de solicitar una determinación de cobertura especial conocida como “excepción” si piensa que:

- Necesita un medicamento que no está en la lista de su plan. A la lista de medicamentos cubiertos se le conoce como “formulario;”
- Una regla de cobertura (como la autorización previa o un límite de cantidad) no debe aplicarse debido a su problema médico; o
- Necesita tomar un medicamento no preferido y usted quiere que su plan lo cubra al precio de un medicamento preferido (un copago más bajo).

Lo qué necesita hacer

Usted o la persona que le ha recetado el medicamento pueden pedirle al plan una determinación de cobertura, llamando al número gratis que aparece en la parte de atrás de la tarjeta del plan, o visitando el sitio web del plan. Usted o su médico puede pedir una determinación acelerada (24 horas) si su salud pudiera estar en peligro si tiene que esperar 72 horas para obtener la respuesta. Usted tendrá que informarle al plan:

1. El nombre del medicamento que no pudo obtener, la dosis y concentración si lo sabe.
2. El nombre de la farmacia donde intentó obtener el medicamento.
3. La fecha en que intentó obtenerlo.
4. Si solicita una excepción, el médico que lo recetó tiene que enviarle a su plan una declaración explicándole el motivo por el cual usted necesita el medicamento que no está en el formulario, el medicamento no preferido o no se debe aplicar una regla de cobertura a usted.

Su plan Medicare de medicamentos recetados le comunicará su decisión por escrito. Si no aprueban la cobertura, la carta del plan le explicará el motivo y cómo apelar la decisión si no está de acuerdo.

Si desea más información, consulte los materiales del plan o llame al 1-800-MEDICARE.

Formulario de CMS-10147-Spanish
Appendix H - Ohio Medicaid Addendum

Medicaid Addendum

This Addendum will supplement the Provider Agreement between Caremark and Provider effective upon Provider's provision of Pharmacy Services to Eligible Persons enrolled in a managed care plan contracting with the Ohio Department of Medicaid's managed Medicaid program and runs concurrently with the terms of the Provider Agreement. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

**ADDENDUM DEFINITIONS**

<table>
<thead>
<tr>
<th><strong>Agreement/Base Contract</strong></th>
<th>The contract between the MCP and the subcontractor (delegated entity)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Plan (MCP)</strong></td>
<td>A Medicaid managed care plan that enters into a provider agreement with ODM to serve Medicaid consumers, which may include dual-eligible consumers who are enrolled in the MyCare Ohio program (aka Integrated Care Delivery System or ICDS) Plans</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>Medical assistance provided under a state plan approved under Title XIX of the Social Security Act</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>A Medicaid recipient enrolled under the care management system pursuant to ORC 5167</td>
</tr>
<tr>
<td><strong>OAC</strong></td>
<td>Ohio Administrative Code</td>
</tr>
<tr>
<td><strong>ODM</strong></td>
<td>Ohio Department of Medicaid</td>
</tr>
<tr>
<td><strong>ORC</strong></td>
<td>Ohio Revised Code</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>A hospital, health care facility, physician, dentist, pharmacy or otherwise licensed, certified, or other appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCP’s Member</td>
</tr>
</tbody>
</table>

**Addendum Provisions**

The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

Participating providers providing health care services to MCP’s Medicaid Members agree to abide by all of the following specific terms:

1. Provider agrees that with the exception of any Member copayments the MCP has elected to implement in accordance with OAC rule 5160-26-12, the MCP’s payment constitutes payment in full for any covered service and will not charge the Member or ODM any copayment, cost sharing, down-payment, or similar charge, refundable or otherwise. This Base Contract does not prohibit Nursing Facilities (NFs) or waiver entities from collecting patient liability payments from Members as specified in OAC rule 5160:1-6-05.1 and 5160:1-6-05.2 or Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODM as specified in OAC rule 5160-28.
   a. MCP shall notify the provider whether MCP has elected to implement any Member copayments and, if applicable, under what circumstances Member copayments are imposed in accordance with OAC rule 5160-26-12.
   b. Provider agrees that Member notification regarding any applicable copayment amounts must be carried out in accordance with OAC rule 5160-26-12.

2. Provider agrees not to hold liable ODM and the Member in the event that the MCP cannot or will not pay for
covered services performed by the provider pursuant to the Base Contract with the exception that:

a. FQHCs and RHCs may be reimbursed by ODM in the event of MCP insolvency pursuant to Section 1902(bb) of the Social Security Act.

b. The provider may bill the Member when the MCP has denied prior authorization or referral for the services and the following conditions are met:
   
   i. The Member was notified by the provider of the financial liability in advance of service delivery;
   
   ii. The notification by the provider was in writing, specific to the service being rendered, and clearly states that the Member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and
   
   iii. The notification is dated and signed by the Member.

3. Provider agrees to cooperate with the MCP’s quality assessment and performance improvement (QAPI) program in all the MCP’s provider subcontracts and employment agreements for physician and nonphysician providers.

4. The MCP shall disseminate written policies that include detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68) and section 5162.15 of the Revised Code, any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCP’s policies and procedures for detecting and preventing fraud, waste and abuse; and the provider agrees to abide by the MCP’s written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

5. Provider agrees to abide by the MCP’s written policies related to the requirements of 42 U.S.C. Section 1396a(a)(68) and section 5162.15 of the Revised Code, including the MCP’s policies for detecting and preventing fraud, waste, and abuse.

6. Provider agrees to cooperate with the ODM external quality review as required by 42 CFR 438.358 and described in OAC Chapter 5160 and on-site audits as deemed necessary based on ODM’s periodic analysis of financial, utilization, provider panel, and other information.

7. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination apply to this Addendum.

8. Notwithstanding item 7 of this Addendum, the MCP must give the provider at least sixty (60) days prior notice for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the Base Contract be terminated sooner or when the contract is temporary in accordance with 42 CFR 438.602 and the provider fails to enroll as an ODM provider within one hundred twenty (120) days.

9. Notwithstanding item 7 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

   a. The provider gives the MCP at least sixty (60) days’ prior notice for the nonrenewal or termination of the Base Contract. The effective date for the non-renewal or termination must be the last day of the month; or

   b. ODM has proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10(G), regardless of whether the action is appealed. The provider’s nonrenewal or termination notice must be received by the MCP within fifteen (15) working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, Provider must extend the nonrenewal or termination date to the last day of the subsequent month.
10. The procedures to be employed upon the ending, nonrenewal, or termination specified in the Base Contract, apply to this Addendum. Provider agrees to promptly supply all records necessary for the settlement of outstanding claims.

11. Notwithstanding items 8 and 9 of this Addendum, in the event of a hospital provider’s proposed nonrenewal or termination of the Base Contract, the hospital provider agrees to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the Base Contract and the last date the hospital will provide services to Members under the Base Contract. This notice must be sent at least forty-five (45) calendar days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues less than forty-five (45) calendar days prior notice to the MCP, the notice to Providers who have admitting privileges at the hospital must be sent within one working day of the hospital provider issuing notice of nonrenewal or termination of the Base Contract.

12. Provider agrees to release to the MCP any information necessary for the MCP to perform any of its obligations under the ODM provider agreement, including but not limited to compliance with reporting and quality assurance requirements. Provider agrees the released information will be shared with ODM or ODM designee upon request to the MCP.

13. Provider must supply, upon request, the business transaction information required under 42 C.F.R. 455.105.

14. Provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract and provider and all employees of the provider are not excluded from participating in federally funded health care programs.

15. If the provider is a Medicaid provider, provider must meet the qualifications specified in OAC Chapter 5160, including rule 5160-26-05(C).

16. All laboratory testing sites providing services to Members must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

17. Home health providers must meet the eligible provider requirements specified in OAC Chapter 5160-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.

18. Provider shall be compensated pursuant to the method and in the amounts specified in the corresponding network enrollment forms of the Base Contract.

19. Provider agrees to provide services to all eligible Medicaid consumer populations as specified in the Ohio Department of Medicaid Provider Agreement. Indicate one or both:

- [ ] Medicaid non-dual populations
- [x] MyCare Ohio Medicare/Medicaid populations

Provider may contact Caremark to change the above indication.

20. Provider agrees to provide services to MyCare Ohio consumers within the designated service area.

21. If the provider is a third party administrator (TPA), the provider agrees to include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontractors will forward information to ODM as requested.

22. Provider agrees to provide services as enumerated in Attachment D of this Addendum (within the provider’s scope of practice).

23. Provider agrees to serve Members through the last day the Base Contract is in effect.
24. Any amendment to the Attachment D and the network enrollment forms specified in item 18 and item 22 must be agreed to in writing by both parties.

25. If Provider is a primary care provider (PCP), Provider agrees to participate in the care coordination requirements outlined in OAC Chapter 5160, including rule 5160-26-03.1.

26. If Provider is a hospital or hospital system, the Addendum must include the completed ODM Hospital Services Form, Attachment C of this addendum, which specifies which services of the hospital are included in the Base Contract.

27. MCP agrees not to prohibit, or otherwise restrict a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the following:
   a. The Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered
   b. Any information the Member needs in order to decide among all relevant treatment options
   c. The risks, benefits, and consequences of treatment versus non-treatment
   d. The Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

28. Provider agrees in providing health care services to Members to identify and where indicated arrange, pursuant to the mutually agreed upon procedures between the MCP and Provider for the following at no cost to the Member:
   a. Sign language services.
   b. Oral interpretation and oral translation services.

29. MCP agrees to fulfill the Provider’s responsibility to mail or personally deliver notice of the Member’s right to request a state hearing whenever the Provider bills a Member due to the MCP’s denial of payment of a Medicaid service, as specified in OAC Chapter 5160 including rule 5160-26-08.4, utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.

30. Provider agrees to contact the MCP’s designated 24-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC Chapter 5160, including rule 5160-26-03(G).

31. Provider agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting Members by mail.

32. Provider agrees not to bill Members for missed appointments.

33. Provider shall not discriminate in the delivery of services based on the Member’s race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

34. Provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

35. Provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for
the performance of services under the subcontract on account of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, health status, or ancestry.

36. Provider shall be bound by the same standards of confidentiality which apply to ODM and the state of Ohio as described in OAC rule 5160-1-32 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

37. Provider agrees that their applicable facilities and records will be open to inspection by the MCP, ODM or its designee, or other entities as specified in OAC rule 5160-26-06.

38. Provider agrees that the Base Contract and Addendum are governed by and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP.
   a. ODM will notify the MCP and the MCP shall notify the Provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP.
   b. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.
   c. The MCP shall notify the Provider of all applicable contractual obligations.

39. Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

40. Provider must retain and agrees to allow the MCP access to all Member medical records for a period of not fewer than eight (8) years from the date of service or until any audit initiated within the 8-year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in OAC rule 5160-26-06.

41. Provider agrees to make patient medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the patient.

42. Provider agrees that if the base contract, with the MCP, provides for assignment to another entity, no assignment, in whole or in part, shall take effect without sixty (60) days prior notice to the MCP.

43. Provider agrees to immediately forward any information regarding a member appeal or grievance, as defined in OAC 5160-26-08.4 or 5160-58-08.4, for processing.

44. If Provider is a primary care provider (PCP), a specification, appearing above the signature(s) on the signature page in all PCP subcontract, stating the maximum number of MCP members that each PCP can serve at each practice site for that MCP.

The Ohio Department of Medicaid permit changes to Attachments A, B, C and/or D by mutual written agreement of both parties and without renegotiation of the Base Contract or this Addendum.
Attachment A (Primary Care Provider Attestation)
Attachment B (Non-Primary Care Providers)
Attachment C (Hospital Services Form)

[Not applicable]
### Attachment D: Services Provided

Provider agrees to provide services as enumerated below (specify below):

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance transportation</td>
<td>Ambulance transportation</td>
</tr>
<tr>
<td>Ambulance transportation</td>
<td>Mental health and/or substance abuse services</td>
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<tr>
<td>Ambulette transportation</td>
<td>Nursing facility services</td>
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<tr>
<td>Ambulatory Surgery Center</td>
<td>Obstetrical and/or gynecological services</td>
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<td>Advanced practice nurse services specify:</td>
<td>Ophthalmology services</td>
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<tr>
<td>Chiropractic services</td>
<td>Outpatient hospital services</td>
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<tr>
<td>Dental services</td>
<td>Physical and occupational therapy</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td>Podiatry services</td>
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<tr>
<td>Emergency Services</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Family planning services and supplies</td>
<td>Physician services</td>
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<tr>
<td>Federally Qualified Health Center services</td>
<td>Primary care provider services</td>
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<tr>
<td>Home health services/Private Duty Nursing</td>
<td>Renal dialysis</td>
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<tr>
<td>Hospice care</td>
<td>Rural Health Clinic services</td>
</tr>
<tr>
<td>Medical Imaging</td>
<td>Specialty physician services, Specify (e.g., cardiology, allergy, etc):</td>
</tr>
<tr>
<td>Inpatient hospital services</td>
<td>Speech and hearing services</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>Vision (optical) services, including eyeglasses</td>
</tr>
<tr>
<td>Other Click here to enter text.</td>
<td></td>
</tr>
</tbody>
</table>

### Community Behavioral Health Services (included only in the MyCare Ohio benefit package)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacological Management</td>
<td>Ambulatory Detox</td>
</tr>
<tr>
<td>Behavioral Health Assessment</td>
<td>Targeted Case Management for AOD</td>
</tr>
<tr>
<td>Behavioral Health Counseling and Therapy</td>
<td>Intensive Outpatient</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Laboratory urinalysis</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Med –Somatic</td>
</tr>
<tr>
<td>Community Psychiatric Support Treatment</td>
<td>Methadone Administration</td>
</tr>
</tbody>
</table>

### Home and Community Based Services (included only in the MyCare Ohio benefit package)

*Indicates service provider types which may be counted in more than 1 county or region. All others may only count in the county where the provider is physically located.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Home Respite Services</td>
<td>Waiver Nursing Services</td>
</tr>
<tr>
<td>Adult Day Health Services</td>
<td>Home Delivered Meals*</td>
</tr>
<tr>
<td>Waiver Transportation*</td>
<td>Assisted Living Services</td>
</tr>
<tr>
<td>Chore Services*</td>
<td>Home Care Attendant</td>
</tr>
<tr>
<td>Social Work Counseling</td>
<td>Choices Home Care Attendant</td>
</tr>
<tr>
<td>Emergency Response Services*</td>
<td>Enhanced Community Living Services</td>
</tr>
<tr>
<td>Home Modification Maintenance and Repair*</td>
<td>Nutritional Consultation</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Independent Living Assistance</td>
</tr>
<tr>
<td>Homemaker Services</td>
<td>Community Transition Services</td>
</tr>
<tr>
<td>Pest Control*</td>
<td>Alternative Meals Service</td>
</tr>
<tr>
<td>Home Medical Equipment and Supplemental Adaptive and Assistive Device Services*</td>
<td></td>
</tr>
</tbody>
</table>
Appendix I - Appeals Process Documentation Guidelines

*Plan Sponsor-specific information may apply as communicated by Caremark or Plan Sponsor.

***Please Read Thoroughly Prior To Obtaining and Sending Documentation***

1. Introduction:

The enclosed report lists discrepancies found as indicated on the Pharmacy Audit Acknowledgement signed by the pharmacy staff on duty at the audit. You have the opportunity to provide documentation to support your pharmacy’s claims currently considered discrepant. Ensure you provide the correct documentation for the discrepancy type identified. Your immediate attention is important. All documentation must be RECEIVED by Caremark no later than the due date indicated in your cover letter.

2. Documentation Procedures:

   a. **Pharmacy Auditing Discrepancy List**: The enclosed report lists discrepant claims by prescription number and date of fill. The D1 and D2 columns list the code for the discrepancy type.

   b. **Documentation Guidelines**: The enclosed guidelines describe the discrepancy types and the documentation required to resolve those discrepancies.

   c. **ALL** documentation is required to include:
      - Pharmacy NABP number;
      - Prescription number of the claim as listed on the Discrepancy List;
      - Date of fill referred to on the Discrepancy List;
      - Patient’s full name, address and phone number;
      - Additional information as shown on the Discrepancy List for the specific discrepancy type;
      - Statements from the prescribers must be on prescriber letterhead or prescription pad. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician’s office or physician stamp on the letter).

      Documentation submitted must adhere to the Documentation Guidelines. Documentation such as telephone prescriptions, computer generated labels or documents without all the required information will not be accepted.

3. Mailing Instructions:

   All documentation must be sent by the documentation due date on the cover letter and in one package via Certified, Express, Express with tracking, or regular USPS mail. Address your correspondence to:

   Caremark  
   Attn: Audit Documentation  
   Pharmacy Performance MC 020  
   9501 East Shea Boulevard  
   Scottsdale, AZ 85260-6719  
   Phone: 1-866-488-4709  
   Fax: 1-866-310-4135

   Documentation less than fifty (50) pages can be faxed; however, the images must be legible to be considered (e.g., documents on tamper resistant prescription pads may not be legible when faxed).

   Caremark recommends sending documentation with tracking and maintaining a copy of all documentation sent.

   All documentation received will be reviewed, and a Final Audit Discrepancy List will be mailed upon completion of review.

   If you need additional help, please call Caremark Pharmacy Performance at 1-866-488-4709.
<table>
<thead>
<tr>
<th>DISCREPANCY</th>
<th>DEFINITION</th>
<th>Acceptable Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMP</td>
<td>COMPOUND</td>
<td>Compound claim has been selected for review for verification of pricing, quantity, use, etc.</td>
</tr>
<tr>
<td>CPY</td>
<td>COPAY</td>
<td>Copays are required to be collected by pharmacy, where applicable by law, and cannot be waived, reduced, increased, or discounted</td>
</tr>
<tr>
<td>CQ</td>
<td>CUT QUANTITY</td>
<td>Quantity billed is less than that prescribed and less than that allowed resulting in additional refills and undue dispensing fees</td>
</tr>
<tr>
<td>DAW</td>
<td>DISPENSED AS WRITTEN</td>
<td>DAW code submitted was different than the DAW instructions on the prescription</td>
</tr>
<tr>
<td>DDB</td>
<td>DIFFERENT DRUG BILLED</td>
<td>Pharmacy billed a different medication and/or NDC than the one dispensed to the patient</td>
</tr>
</tbody>
</table>
| DIS | DRUG INVOICE SHORTAGE | Drug wholesaler invoices were not sufficient to support quantities billed | All documentation provided for Drug Invoice Shortage discrepancies must include a minimum NDC, product name, quantity, invoice number, and dates of purchase. Acceptable documentation includes the following:
1. A summary report of drug purchases and returns directly from the wholesaler; or
2. Send a copy of the original drug wholesaler invoices, if found; or
3. Documentation of drug purchase via other sources. Further verification of these documents may be required such as proof of payment for stock transfers, payment history, copies of checks for drug stock buy-out, bill of sale, payment invoices, etc. |
<p>| DPC | DUPLICATE PAID CLAIM | Multiple claims for the same prescription fill were submitted | This discrepancy does not require further documentation. |
| DWC | DATE WRITTEN CORRECTION | The written date submitted by the pharmacy does not match the date written on the prescription hardcopy | This discrepancy does not require further documentation. The claim will be reprocessed for the correct date written. |
| ETL | EXCEEDS TIME LIMIT | Prescription was filled or refilled for a time period longer than that allowed by the Plan or applicable regulations | This discrepancy does not require further documentation. |
| GBB | GENERIC vs. BRAND BILLED | A claim was submitted for a brand medication when a generic form of the medication was dispensed | This discrepancy does not require further documentation. |
| INV | INVALID PRESCRIPTION | Prescription was invalid at the time medication was given to the Eligible Person (state and federal regulations, RMPs, altered Rx, etc.) | This discrepancy does not require further documentation. |
| MIF | MISFILL | Prescription dispensed was filled with incorrect drug, strength, directions or patient | This discrepancy does not require further documentation. |</p>
<table>
<thead>
<tr>
<th>DISCREPANCY</th>
<th>DEFINITION</th>
<th>Acceptable Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MP</td>
<td>MISSING PRESCRIPTION</td>
<td>Original hard copy prescription or computer based prescription image cannot be found during the audit</td>
</tr>
<tr>
<td>NPI</td>
<td>INACCURATE PRESCRIBER NUMBER</td>
<td>NPI/DEA number on the prescription did not match the NPI/DEA/prescriber identification number on the claim. The NPI/DEA number is required to be accurate on all controlled substances</td>
</tr>
<tr>
<td>NSL</td>
<td>NO SIGNATURE LOG</td>
<td>The signature documenting receipt of the prescription drug cannot be found in the signature logs or the electronic database</td>
</tr>
<tr>
<td>OBC</td>
<td>OVER BILLED COMPOUND</td>
<td>Compound claim has been reviewed for pricing, quantity, and use. The allowable amount is listed in the Comments field. The adjusted Discrepant Amount will appear on the final Discrepancy Report</td>
</tr>
<tr>
<td>OBQ</td>
<td>OVER BILLED QUANTITY</td>
<td>Quantity billed exceeded the amount authorized by the prescriber, the quantity allowed under the plan, or the quantity dispensed exceeds the days supply submitted</td>
</tr>
<tr>
<td>OTH</td>
<td>OTHER</td>
<td>A miscellaneous discrepancy type</td>
</tr>
<tr>
<td>PRD</td>
<td>PRESCRIBER DENIED</td>
<td>Prescription was denied by the prescriber that was on the claim</td>
</tr>
<tr>
<td>PTD</td>
<td>PATIENT DENIED</td>
<td>Patient denied requesting and/or receiving the prescription</td>
</tr>
<tr>
<td>DISCREPANCY</td>
<td>DEFINITION</td>
<td>Acceptable Documentation</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>RTS</td>
<td>REFILL TOO SOON Prescription was refilled sooner than appropriate due to an incorrect days supply on the previous fill date. If Provider dispenses the smallest commercially available package size and enters a day supply based on plan limits, Provider maintains responsibility to adhere to appropriate refill intervals</td>
<td>This discrepancy does not require further documentation.</td>
</tr>
<tr>
<td>SIG</td>
<td>INSUFFICIENT DIRECTIONS FOR USE</td>
<td>Obtain specific dosing instructions from the prescriber. If dosing is prn, specify patient’s maximum weekly or monthly usage. Documentation outlining the patient’s dose must be obtained from the prescriber on prescriber’s letterhead or on a written Rx from the prescriber. The prescriber may fax the documentation to the pharmacy. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician’s office or physician’s stamp on the letter). No notes or verbal conversations with prescriber or office staff will be accepted.</td>
</tr>
<tr>
<td>UAR</td>
<td>UNDOCUMENTED AUTHORIZATION OF REFILL</td>
<td>Send a signed statement from the prescriber on prescriber letterhead or on a written Rx from the prescriber, authorizing the dispensing. This must include medication, quantity, directions for use, original fill date and authorized refill dates. The prescriber may fax their documentation to the pharmacy. Attestations provided by the physician must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician’s office or physician’s stamp on the letter). *COMPUTER GENERATED, TELEPHONE PRESCRIPTIONS, TRANSFER RXs, WILL NOT BE ACCEPTED.</td>
</tr>
<tr>
<td>VAF</td>
<td>VACCINE ADMINISTRATION FEE</td>
<td>1. Send a copy of a vaccine administration log with the signature highlighted, if found; or 2. Send a signed statement from the patient verifying the vaccine was administered.</td>
</tr>
<tr>
<td>WP</td>
<td>WRONG PATIENT</td>
<td>Send a signed statement from the cardholder indicating that the patient whose name is on the prescription is covered by the indicated plan.</td>
</tr>
</tbody>
</table>
Appendix J – Dispensing Practitioner

To the extent Provider is a Dispensing Practitioner, the terms of this Appendix J apply to Provider, in addition to other terms of the Agreement, and Provider agrees to the terms of this Appendix J. A “Dispensing Practitioner” is defined as a duly licensed and established practitioner (e.g., MD, DO, RN, NPA, and RPh) operating under a medical license or other appropriate license and that dispenses and sells Covered Items to Eligible Persons through in-person hand delivery at the point of care, solely to the dispensing practitioner’s patients in the regular course of the practitioner’s practice. In the event any provision in this Appendix J conflicts with a term of the Provider Agreement (including the Provider Manual and Caremark Documents), the terms of this Appendix J shall govern.

1. Caremark reserves the right to limit the participation of Dispensing Practitioner as may be appropriate under applicable Law.

2. Pre-Enrollment and Post-Enrollment Credentialing
Caremark will conduct credentialing of Dispensing Practitioners based on Caremark’s credentialing and quality management standards for both new applicants and enrolled Dispensing Practitioners. Dispensing Practitioner agrees that failure to meet Caremark’s credentialing and quality management standards may result in denial of enrollment, or with respect to currently enrolled Dispensing Practitioners, termination of the Provider Agreement. An enrollment application must be completed by the Provider or an employee of Provider. Caremark charges a $1500 fee (per NCPDP number) for each enrollment application regardless of whether Caremark enrolls Provider. Payment of the $1500 enrollment fee must be transmitted to Caremark by Provider or the offices of Provider. Caremark charges a $75 fee per dispensing location for each additional request Caremark makes to obtain required documentation and information to complete the enrollment application. Caremark may require pre-enrollment on-site or telephone compliance review to assess Provider’s operational practices and compliance with the Provider Agreement.

3. Compliance with Law
Provider must follow all applicable Law (e.g., state medical board Law) related to dispensing of Covered Items by a practitioner, including but not limited to, records retention and minimum standards of practice. Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons in accordance with applicable Law. Such documents and records may include, but are not limited to, original prescriptions; signature logs; daily prescription logs; wholesaler, manufacturer and distributor invoices; Prescriber information; and patient profiles as in accordance with the Provider Manual.

With respect to Part D claims, Provider agrees to make its books and records available in accordance with, and for the period required by 42 CFR §423.505(i)(2), which gives HHS, the Comptroller General, or their designees, the right to audit, evaluate and inspect any books, contracts, records, including medical records, and documentation of Provider involving transactions related to CMS’ contract with a Part D Plan Sponsor, and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor’s contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the (ten) 10 year retention period. Provider also agrees to maintain records and provide access in accordance with 42 CFR 423.505(b)(10).

4. Licensure and Reporting of Actions
Provider must maintain all required licensure and/or certifications required to be a Dispensing Practitioner in accordance with applicable Law. Provider must notify Caremark in writing within ten (10) business days if Provider’s ability to dispense or practice as a licensed practitioner is suspended or revoked, or is in jeopardy of being suspended or revoked or is in any other way limited. Provider’s written notice to Caremark must include a detailed description of the issues and allegations.
5. **Standards of Operation**

Provider must meet the standards of the community with regards to dispensing of prescriptions, meeting or exceeding those standards of a reasonable pharmacist.

All Pharmacy Services must be provided by or under direct supervision of Provider. Provider must utilize professional judgment in the dispensing of medication. Provider agrees that Caremark is not responsible for Provider’s actions based on Provider’s professional judgment.

Prior to dispensing, Provider must provide the patient a written or e-scribe prescription and advise (and document) the patient that the prescription can be filled by a pharmacy of his or her choice.

Provider must physically initial the dispensing record (i.e., refill log, controlled substance log, prescription hardcopy, and prescription label) and the dispensed Covered Item.

Consistent with requirements under state law or standards of care in Provider’s state, Provider must maintain a drug use review program to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results.

Provider may only dispense to patients under Provider’s medical care.

Provider (through a licensed individual) must counsel the patient on the medication and record that the consultation was performed or declined.

Dispensed prescriptions must affix a prescription label that includes all elements as defined by the applicable state Board of Pharmacy for dispensing by a pharmacist, even in the absence of a requirement by the state Board of Medicine or state Board of Pharmacy for a prescription label for Dispensing Practitioner dispenses.

Provider must not compound or dispense compound kits unless the medication is dispensed for a patient under Provider’s direct care and within Provider’s specialty (e.g., oncology).

Provider must review state prescription drug monitoring programs (PDMP) prior to prescribing as required by applicable Law, and must report information to PDMPs and review PDMPs as a dispensing practitioner as required by applicable Law.

6. **Drug Inventory**

Provider must manage its drug inventory, order its own inventory, and dispense its own medications. Provider must not outsource its dispensing function.

Provider must meet Drug Quality Security Act (DQSA) standards, including drug recall standards.

Provider must have sufficient drug stock in order to meet the needs of its patients. Drug inventory must be securely stored, and all record keeping requirements must be satisfied.

7. **Claims Submission**

Provider’s claims submission must utilize the NPI of the provider where the Covered Item was dispensed to the Eligible Person, unless Caremark expressly authorizes otherwise in writing. Claims submission utilizing an identification number other than the provider who dispensed the Covered Item to the Eligible Person is subject to audit review and chargeback, and is not eligible for reimbursement.

Claims submission to Caremark must be performed by Provider at the dispensing location, and Provider must not use a third party vendor to submit claims; claims submitted in violation of this requirement is subject to chargeback and is not eligible for reimbursement.

Provider must not bill both the Plan’s medical and pharmacy benefits for the same claim; otherwise, such claims are subject to chargeback.
8. **Payment**
Caremark will only remit payments in the name of Provider, directly to the location where the dispensing activity occurred.

9. **Application Submission**
All credentialing documents including Standard Operating Procedures should be written and submitted via the Caremark Pharmacy Portal by in-office dispensing physician or in-office staff. Refer to section 1.06 Pharmacy Portal of the Provider Manual.

Application submission to Caremark must be performed by Provider at the dispensing location. Provider must not use a third party vendor to submit application. Applications submitted in violation of this requirement are subject to application denial and/or termination of contract. In-office dispensaries with PSAOs that have not received log-in information from Caremark can direct their Caremark Network Account Manager.

The information provided in the Pharmacy Portal is CVS Caremark’s confidential and proprietary information and considered “Confidential Caremark Information” as this term is defined in the Caremark Provider Manual. Pursuant to the terms of the Caremark Provider Manual, you may not disclose, sell, assign, transfer, or give the information contained therein to any third party.
Glossary of Terms

Caremark Documents means the Provider Agreement, schedules thereto, addenda, the Provider Manual and all attachments thereto including this Glossary of Terms, Federal Laws and Regulations, State Laws and Regulations, information transmitted by Caremark to Provider through the claims adjudication system, and information transmitted by Caremark to Provider specifically designated by Caremark as a “Caremark Document” which may include educational materials related to products, programs, services, and Plan Sponsor announcements.

AWP or Average Wholesale Price means the current wholesale cost of a given drug as defined in the latest edition of Medi-Span (with supplements), MICROMEDEX, or any other similar nationally recognized reference which Caremark may reasonably select from time to time.

AWP Discount means the AWP percentage discount that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Chargeback means collection by Caremark of amounts paid to a Provider, in whole or in part, that were determined to be owed, including but not limited to, amounts for discrepant claim(s), claim(s) submitted in breach of the Agreement, or identified overpayment(s).

Confidential Caremark Information means any non-public information or data of Caremark and includes but is not limited to, (1) Caremark’s products, programs, services, designs, inventions, business practices, policies and procedures, customer list, information related to a Plan Sponsor, trade secrets; (2) MAC lists; (3) reimbursement rates and terms; (4) the Provider Agreement, the Provider Manual, network enrollment forms and other addenda, and all other Caremark Documents; and (5) other information relating to Caremark’s business.

Covered Item means any drug or device covered, in whole or in part, in accordance with and subject to the terms of a Plan covering an Eligible Person.

Dispensing Fee means the dispensing fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claims adjudication system, each as may be amended from time to time.

Dispensing Pharmacy means the pharmacy that is giving or delivering the Covered Item to the Eligible Person.

Dispensing Practitioner means a duly licensed and established practitioner (e.g., MD, DO, RN, NPA, and RPh) operating under a medical license or other appropriate license and that dispenses and sells Covered Items to Eligible Persons through in-person hand delivery at the point of care, solely to the dispensing practitioner’s patients in the regular course of the practitioner’s practice.

Eligible Person means a person or animal entitled to a Covered Item pursuant to a Plan.

Law means any Federal, State, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, sub-regulatory guidance (including but not limited to, CMS Prescription Drug Benefit Manual, model contracts between the State Medicaid Agency and managed care organizations, and other guidance from State Medicaid Agencies, such as Medicaid Manuals, Bulletins, and other issuances), order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) a condition of granting any applicable permit, license or approval required by Caremark, Provider, or a Plan Sponsor, or other legislative or administrative action of the United States of America, or state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

Licensed Pharmacist means a pharmacist licensed in the United States (including U.S. territories).

MAC or Maximum Allowable Cost means a unit price that has been established as the reimbursement amount to Provider for certain multiple-source drugs without regard to the specific manufacturer whose drug is dispensed.

Medical Foods: The term medical food, as defined in section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is “a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinct nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

Patient Pay Amount means the amount an Eligible Person must pay to Provider at the time a Covered Item is dispensed as indicated by the claims adjudication system, which may include but is not limited to copayments, coinsurance, deductibles, transaction fees, access fees, and/or taxes.

Pharmacy Services/Provider Services means all services including the provision of prescription drugs usually
and customarily rendered by a Provider and Licensed Pharmacist or Dispensing Practitioner licensed to provide pharmacy services in the normal course of business, including services mandated by applicable Law. Pharmacy Services may include, but not be limited to: the maintenance of Eligible Person profiles; the interpretation of prescriptions; the selection of medications and medical devices; the sale of compounding or dispensing of medications and medical devices (also includes Over-the-Counter medications [OTCs] and supplies covered by or used in conjunction with a pharmacy benefit); the counseling of Eligible Persons, which may consist of information about the proper storage, dosing, side effects, potential interactions and use of the medication dispensed; the monitoring of appropriate drug use; and the implementation of drug utilization review programs and other clinical programs and services.

**Plan** means that portion of a Plan Sponsor’s pharmacy benefit plan that relates to Covered Items with respect to a group of Eligible Persons.

**Plan Sponsor** means the entity that contracts with Caremark or any of Caremark Rx, L.L.C.’s affiliates for pharmacy benefit management services, which entity could be, among other things, an insurance company, self-insured group, health maintenance organization, preferred provider organization, multi-employer trust or third party administrator.

**Prescriber** means a physician, dentist, physician’s assistant, optometrist or other health care professional authorized by law to write prescriptions for prescription drugs within the scope of practice as designated by regulatory agency.

**Price Type** means a current price of a given drug as defined by a nationally recognized reference that Caremark may reasonably select from time to time, which may include, but is not limited to: AWP (Average Wholesale Price), WAC (Wholesale Acquisition Cost), AMP (Average Manufacturer Price), ASP (Average Sales Price), DP (Direct Price), or Federal Upper Limit (FUL).

**Provider** means a provider of Pharmacy Services that is the signatory to the Agreement and who must provide all services including the provision of prescription drugs usually and customarily rendered by a provider, Licensed Pharmacist or Dispensing Practitioner licensed to provide such Pharmacy Services in the normal course of business, including services mandated by applicable Law.

**Retail Pharmacy** means a duly licensed and established community pharmacy or dispensing practitioner that serves walk-in patients and that dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. Participation in Caremark’s retail networks is limited to pharmacies (or dispensing practitioners) that are a “Retail Pharmacy”. **Refer to section 3.04 Standards of Operation** of the Provider Manual.

**Third-Party Agreement** means an agreement between Caremark and a Caremark client in which Caremark serves as an auditor for that client’s participating network pharmacies.

**Usual and Customary Price or U&C** means the lowest price Provider would charge to a particular customer if such customer were paying cash for an identical prescription on that particular day at that particular location. This price must include any applicable dispensing fee and/or level of effort. This price must include any applicable discounts offered to attract customers.

**Wholesale Acquisition Cost or WAC** means the current wholesale acquisition cost of a given drug as defined in the latest edition of Medi-Span (with supplements), MICROMEDEX, or any other similar nationally recognized reference which Caremark may reasonably select from time to time.