Prime Therapeutics 2005

PHARMACY PROVIDER MANUAL

PRIME Therapeutics®

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INTRODUCTION

Prime Therapeutics LLC (Prime) is a prescription benefit management company that provides comprehensive pharmacy management solutions to our clients through unique services. Some of these services include:

- Pharmacy Networks
- Formulary Management
- Pharmacy Communication
- Drug Utilization Review (DUR)
- Clinical Programs
- Physician Education

Prime encourages the use of safe and cost-effective therapies for our clients while maintaining a valued relationship with the pharmacy network. Prime promotes the use of local programs to meet the needs of our clients, and encourage the important connection a pharmacist maintains with his or her patients.

Prime manages pharmacy networks to provide Prescription Drug Services for its clients through Prime's on-line Point-of-Sale (POS) claim adjudication system.

The POS system gives Pharmacies real-time access to patient eligibility, drug coverage, prior-authorization drugs, DUR information, MAC pricing schedules, and dispensing fees as specified by the client and the Pharmacy Agreement (Agreement) with Prime.

The purpose of this Pharmacy Provider Manual is to explain Prime's administrative policies and procedures, as amended from time to time. The date of this manual is September 1, 2005. It is considered an attachment to your participating provider Agreement. Any changes to the Pharmacy Provider Manual distributed by Prime will be considered amendments to the Agreement. If there is a conflict between the Pharmacy Provider Manual and the Agreement, the Agreement will govern.

PRIME CONTACT INFORMATION

If you would like additional information, please contact Prime.

Prime Therapeutics LLC
P.O. Box 64812
St. Paul, Minnesota 55164-0812

Prime Contact Center Phone Numbers

Prime Pharmacy Line:
800.821.4795

Dedicated RXCare Wyoming:
800.424.7094

Dedicated Blue Cross and Blue Shield of Kansas:
877.893.8485

The Prime Contact Center has dedicated staff to assist pharmacies with processing questions or problems. Our representatives are available from 7:00 a.m. to 11:00 p.m. Monday through Friday and 7:30 a.m. to 6:00 p.m. Saturday and Sunday (all times are Central). Representatives are also available on-call for emergency situations. Please follow the prompts if calling after business hours.

ADDITIONAL INFORMATION

Pharmacy Network Management:
800.858.0723

Prime web site:
www.primetherapeutics.com

Visit the Prime web site for the following information:

- *Prime Perspective*™ Newsletter
- New plan announcements
- Operating guidelines
- Requests and inquiries
- Frequently asked questions
- Contact information
- Exception request forms
- Formulary information
- MAC program information
- Payor sheet
- Payment information
- Additional policies and procedures

Prime Contact Center Phone Numbers

Prime Pharmacy Line	**800.821.4795**
Dedicated RXCare Wyoming	**800.424.7094**
Dedicated Blue Cross and Blue Shield of Kansas	**877.893.8485**

RESPONSIBILITY OF PHARMACY

A summary of Pharmacy responsibilities in accordance with the Agreement with Prime.

Pursuant to the Agreement, Pharmacy shall:

- Not discount or waive required Copayments, deductibles, Ancillary Charges, or any other applicable charges
- Provide Prescription Drug Services to all Covered Persons in accordance with the standard of practice of the communities in which the Pharmacy provides services. Service should be provided without regard to race, religion, sex, color, national origin, age, or physical or mental health status, upon the written or verbal prescription order or refill from a Prescribing Provider
- Submit all claims on-line to Prime for adjudication within 90 days from the date the prescription is dispensed using NCPDP format 5.1, or another version as indicated by Prime
- Submit the Usual and Customary Charge (U&C) for all claims for Prescription Drug Services processed through the Prime POS claim adjudication system or through another claims processor as designated by Prime
- Submit the National Drug Code (NDC) from the original package size from which the prescription drug was dispensed.
- Comply with the Drug Formulary unless otherwise directed by the Prescribing Provider to dispense the prescription "Brand Necessary," "DAW," etc.
- Collect all applicable Copayments, deductibles, Ancillary Charges, or other applicable charges from the Covered Person as indicated by the Prime POS claim adjudication system
- Collect only the transmitted amount as indicated by the POS claim adjudication system for Prescription Drug Services. Under no circumstances shall Pharmacy collect or attempt to collect additional fees for Prescription Drug Services provided under the Agreement

- Verify "as directed" prescription orders by contacting the Prescribing Provider to verify directions. If the Prescribing Provider is unavailable, Pharmacy should ask the Covered Person how he or she was instructed to take the prescription drug
- Maintain a signature log that contains the signature of the Covered Person or designee, indicating receipt of the Prescription Drug. Mailed or delivered prescriptions should be noted on the signature log with the date of delivery. An electronic transaction log may be used instead of a signature log

Dispensed Package Size

When Pharmacy submits a claim for a Prescription Drug Service provided by Pharmacy, Pharmacy must submit the National Drug Code (NDC) number for the original package size from which the Prescription Drug Service was dispensed. The quantity of the Prescription Drug Benefit dispensed shall comply with the dispensing limitations obtained through the on-line POS system.

Prescriptions may not be separated and dispensed by doses. If separate packaging is required, the pharmacy must use a duplicate label. For example, a dose required in school or adult care center should not be dispensed as a separate prescription.

Return to Stock — Unclaimed Prescriptions

Each Prescription Drug Service approved for Pharmacy Payment but not received by Covered Person within 10 (ten) days of submission must be reversed on-line by the Pharmacy.

Sanitation

A pharmacy must have a clean working environment. A licensed pharmacist must be on duty and all licenses must be valid and displayed in full public view.

Maintain Licenses

Pharmacy agrees to maintain any licensed status required by applicable laws for its continued operation. Failure to comply with this provision shall be a basis for termination for cause and other damages. Pharmacy represents and warrants that all locations identified on Exhibit A of the Prime Participating Provider Agreement are duly licensed in the jurisdiction in which they are located, and Pharmacy will require that all locations are bound by the terms and conditions of the Agreement.

BENEFIT PLAN

A Benefit Plan contains the terms and conditions of a Covered Person's outpatient prescription drug benefit. There are a variety of benefit designs supported by Prime.

Existing benefits may change without prior notice to Pharmacy. New benefit plans may be added at the request of a client. The POS claim adjudication system will provide Pharmacy with current benefit information.

Brief explanations of common benefit designs are listed in the following sections. Please keep in mind that these conditions may or may not apply to a particular Benefit Plan. If you have questions about any benefit limitation, please call the Prime Contact Center.

Quantity Limit

Many Benefit Plans restrict the quantity that may be dispensed on certain drugs, which may include, but are not limited to, Erectile Dysfunction medications, Migraine medications, Pain Management medications, PPIs or Tobacco Cessation medications. These limits follow clinical dosing guidelines and restrict the dispensing of the drug to a maximum quantity. When submitting a claim that exceeds the maximum quantity, the claim will reject with NCPDP code 76 "Plan Limits Exceeded." A free-form text message will accompany the reject and indicate the maximum quantity that may be dispensed. Please rely on POS messaging for accurate quantity limits.

Pharmacy should reduce the quantity prescribed and provide refills if the quantity exceeds the member's benefit. Pharmacy may reduce the quantity prescribed if the member requests a smaller amount. Pharmacist should document hard copy to reflect patient request.

Benefit Plan Exclusions

Some Benefit Plans exclude coverage of certain prescription drugs. When a claim is submitted for a non-covered drug, Pharmacy will receive NCPDP reject code 70, "Product/service not covered." Common drugs in this category include, but are not limited to, Mifeprex, Dietary and Herbal supplements, Over-the-Counter medications, Diagnostic agents, Non-FDA approved medications, General Anesthetic, Blood Components, and Durable Medical Equipment.

Generic Mandate

Some benefit designs require the Covered Person to pay the ancillary charge when a brand-name drug is dispensed that has an equivalent generic product that is included on Prime's Maximum Allowable Cost (MAC) list.

PSC 1 Override

(product selection code formerly known as DAW)

A limited number of Benefit Plans allow the Prescribing Provider to request that the brand-name product be dispensed instead of an equivalent generic without passing an Ancillary Charge to the Covered Person. The claim must be submitted with a PSC of 1 to override the pricing and to provide payment for the brand-name product.

If PSC 1 is used in processing a claim, the written prescription must contain documentation of the 'Dispense As Written' order from the prescribing provider. If the prescription is telephoned in, the pharmacist must manually write on the written prescription document 'Dispense As Written.'

PSC 2 Override

Some Benefit Plans allow the Covered Person to request a brand-name product instead of an equivalent generic without paying an ancillary charge. Pharmacy should indicate on the prescription that the Covered Person requested the brand and submit the claim using a PSC of 2. A majority of Benefit Plans have elected to not recognize PSC 2.

Tiered Copays

This benefit design allows the Prescribing Provider or Covered Person to choose brand or generic, and formulary or non-formulary medications, but requires the Covered Person to pay a higher Copayment for brand and non-formulary drugs.

100% Copay

Some Benefit Plans allow the Covered Person to receive medications at the contracted rate, but require full payment of the prescription by the Covered Person at the point of sale.

Age Restrictions

Some Benefit Plans exclude coverage for certain medications once a Covered Person reaches a certain age. Common drugs in this category include, but are not limited to, Retin-A, Azelex, Differin and Synagis.

Step Therapy/Contingent Therapy Programs

Some Benefit Plans require the Covered Person to try one or more preferred medications before a non-preferred medication will be allowed for payment.

Mandatory Mail Order

Some Benefit Plans limit a Covered Person's ability to utilize a retail pharmacy when a maximum number of fills/refills are met. This limitation varies by Benefit Plan and could apply to only maintenance drugs or to all products covered by the Plan.

GENERAL BENEFIT EXCLUSIONS

Benefit Plans vary between Benefit Sponsors as well as between groups of a Benefit Sponsor. Please rely on POS messaging for accurate benefit information.

Unless otherwise indicated through the on-line claim adjudication system, the following Prescription Drug Services are generally not covered:

- Medical appliances or devices (inhalation devices, ostomy supplies, durable medical equipment)
- Over-the-counter (OTC) products and products with an OTC equivalent (except for Medicaid Plans)
- Products used solely for cosmetic purposes
- Compound medications that do not contain a Federal Legend Drug
- Minoxidil topical to treat baldness
- Investigational or experimental drugs
- Contraception devices (diaphragm, Norplant, IUD)
- Refills dispensed one year after the date written on the original prescription; prescriptions must be updated yearly
- Immunization agents
- Medications packaged as unit dose

These are examples only. Coverage is determined by the Covered Person's Benefit Plan as indicated by the on-line claim adjudication system.

GENERAL COVERED BENEFITS

Unless otherwise specified by Prime through the on-line claim adjudication system, the following are considered covered benefits:

- Federal Legend Drugs
- Insulin
- Disposable Insulin syringes and needles
- Compound medications that contain at least one Federal Legend Drug

CLAIMS INFORMATION

ON-LINE CLAIM SUBMISSION

Pharmacy is required to submit all claims on-line to Prime for all Prescription Drug Services provided to a Covered Person including situations where:

- The Pharmacy Payment is applied toward a deductible
- The Copayment equals the Pharmacy Payment
- The Pharmacy Payment is less than the Copayment

Pharmacy must submit claims on-line using NCPDP version 5.1 or another format designated by Prime. Pharmacy has 90 days from the date of service to submit a claim on-line to Prime.

Pharmacy is required to submit U&C on each claim processed through the on-line adjudication system.

On-Line Availability

The on-line system is available for claims processing 24 hours a day, 365 days a year.

Prime maintains two on-line adjudication systems, which will automatically switch processing to the other if one is down. This process provides virtually 100 percent on-line availability.

In the rare event that Prime's system is unavailable, or if a problem occurs at the switch company, Pharmacy should provide the Covered Person with enough medication until the claim can be adjudicated on-line.

Claim Reversal

Pharmacy has 10 (ten) days from the date of service to reverse a claim. Any prescription that has not been delivered or received by a Covered Person must be reversed through the POS claim adjudication system, within 10 (ten) days from date of service.

Claim Adjustment

Prime does not accept partial adjustments through the POS claim adjudication system. If an error has been made during the billing process, and the claim is less than 90 days old, reverse the entire claim and re-bill the claim through the POS system. If the claim is older than 90 days, Pharmacy must submit appeal in writing to Prime.

Pharmacy is required to reverse any claim that is not delivered to or received by the Covered Person for which the claim was processed.

Coordination Of Benefits (COB)

In the near future, on-line COB capabilities will be available. Until such time, use paper claim process as stated above.

Processing Claims for Same Gender Multiples

When processing claims for multiples of the same gender with the same birth date, and same medication, please use the following procedure:

1. Process the first claim as usual

2. Process the second claim

If the second claim rejects, call the Prime Contact Center for a prior authorization. A prior authorization will allow the second claim to adjudicate through the on-line system.

Most clients have activated the multiple-birth flag within their eligibility files. This enhancement allows the system to recognize the first name of the patient submitted on the claim and allows for multiples to receive the same medication on the same day. For this edit to function properly, the name submitted on the claim must match the name as it appears in the Prime system.

Claim Formats

- POS claims must be submitted in the NCPDP version 5.1 format
- Batch claims must be submitted in the NCPDP Batch 1.1. format
- The Universal Claim Form (UCF) must be submitted for paper submissions

Prime's payor specification sheet can be found at **www.primetherapeutics.com** for a complete list of required and/or situational processing requirements.

Copayment Charge

The Copayment is the amount specified by the Covered Person's Benefit Plan that the Covered Person is required to pay to Pharmacy for Prescription Drug Services.

Prime passes back the appropriate Copayment to be collected from the Covered Person when the claim is adjudicated through the on-line system.

- If the amount of the claim exceeds the Copayment, Pharmacy will only collect the Copayment from the Covered Person
- If Pharmacy's U&C is less than the Copayment, Pharmacy collects only the U&C from the Covered Person

If you have questions concerning the processing of multiple-birth claims, please call the Prime Contact Center at **800.821.4795**.

- If a Covered Person's Copayment is less than the U&C, Pharmacy collects only the Copayment
- If an ancillary charge is applied to the claim, Pharmacy collects the Copayment plus the ancillary charge
- Some Benefit Sponsors have chosen to adopt a Minimum Reimbursement Level (MRL). When a Benefit Sponsor implements an MRL, a Contracting Pharmacy will be paid a minimum amount. If an MRL is in place for the Covered Person's Benefit Plan, and the MRL is less than the Covered Persons' Copayment, Pharmacy collects the MRL as the Copayment
- If an MRL is not in place and the amount of the claim is less than the Covered Person's Copayment, Pharmacy collects the total amount of the claim as communicated by the POS system

GENERAL CLAIM INFORMATION

Processor Control Number

Prime requires a separate processor control number for each carrier. A bank identification number (BIN) is also required when adjudicating claims through the on-line POS system. To the right is a list of the processor control numbers and BINs used to adjudicate claims through Prime's POS system. This list is valid as of September 1, 2005.

NDC (National Drug Code)

The NDC number used on the claim shall be the NDC number from Pharmacy's in-stock package size from which the prescription product was dispensed.

BINs and Processor Control Numbers

Payor	BIN	PCN
BCBS Illinois BlueScript	011552	ILSC
BCBS Illinois PPO	011552	ILDR
BCBS Kansas	610455	KSBCS
BCBS Minnesota	610455	PGIGN
BCBS Nebraska HMO	610455	HMONE
BCBS Nebraska PPO	610455	RXNEB
BCBS Nebraska, COOD	610455	PPNI1
BCBS Nebraska, Heartland	610455	HRTLD
BCBS New Mexico	011552	NMDR
BCBS New Mexico – Medicare Advantage PPO	011552	NMMCARE
BCBS North Dakota	610455	NDBCS
BCBS Oklahoma PPO (as processed through BlueLincs)	610435	1215
BCBS Oklahoma, BlueLincs HMO (through BlueLincs)	610435	3607
BCBS Oklahoma, Self-Insured (through BlueLincs)	610435	1400
BCBS Texas	011552	BCTX
BCBS Texas – Medicare Advantage PPO	011552	TXMCARE
BCBS Wyoming	800001	WYBCS
CHS (Cenex Harvest States) – BCBSMN Health plan	610455	PGIGN
CHS (Cenex Harvest States) – Non-Blue	610455	PGNB1
Medicare (PrimeScript)	610455	MEDICARE
Non BCBS Self-Insured Plans	610455	CARVE
PrimeWest	610455	PWEST

Days Supply

Pharmacy should submit the number of consecutive days supply the prescription product will last. Future refills may be rejected if the days supply is submitted inaccurately.

For prescription products that cannot be broken (e.g., inhalers), where the smallest unit available exceeds the Benefit Plan for the Covered Person, Pharmacy should submit the maximum days supply allowed under the Covered Person's benefit.

Example: Covered Person's benefit allows a 34-day supply. One inhaler will last 40 days. Pharmacy should bill the inhaler as a 34-day supply.

In situations where one unit does not maximize the Covered Person's benefit, (e.g., inhalers), Pharmacy should only submit the quantity that falls within the benefit.

Example: Covered Person's benefit allows a 34-day supply. One inhaler will last 28 days. The Covered Person should receive one inhaler.

National Provider Identifier

Until the National Provider Identifier (NPI) numbers are available, Pharmacy must use the Drug Enforcement Agency (DEA) number as identification for the Prescribing Provider.

Some Benefit Plans may require Pharmacy to submit the actual DEA number from the Prescribing Provider or such number that meets the DEA number algorithm.

If a Benefit Plan has a closed provider network, Pharmacy must submit the Prescribing Provider DEA number or last name.

Pharmacy is required to submit the DEA number for all controlled substances.

Compound Drug

Compound Drugs are reimbursed based on the AWP of all the ingredients and total quantity of the compound being dispensed. Preparation time is not used in the calculation of reimbursement for Compound Drugs. Compound Drugs must be submitted through the Prime POS adjudication system using the following guidelines:

- The Compound Drug must contain at least one federal legend ingredient. A Federal Legend Drug by law is one that can be obtained only by prescription and bears the label "Caution, Federal Law prohibits dispensing without a prescription," or "Rx Only"
- All legend products contained in the compound must have a valid NDC number
- The NDC number of the most expensive legend ingredient must be submitted on the claim
- The quantity of the entire compound should be submitted
- The AWP for the entire compound's combined ingredients should be submitted
- Pharmacy should flag the claim as a Compound Drug in its system prior to adjudication
- Bioequivalent compounds of a manufactured product are not covered

For additional processing information, please call the Prime Contact Center at **800.821.4795**.

- Sustained-release and extended-release compounds are not covered

As of September 1, 2005, Prime has not instituted the multiple NDC submission to adjudicate claims for compound medications. Pharmacies should use the procedure above to process compound claims.

Accurate Quantity

The quantity dispensed must be entered exactly as written. Quantities should be submitted as metric quantity (including decimal points) using the NCPDP version 5.1 compatible software. The pharmacy must enter the exact metric decimal quantity, no rounding up or down on claims. Failure to do so may result in a 100 percent charge back.

OTC Products (where applicable)

Price will not exceed shelf price for customer purchase.

Solutions Prescriptions

Solutions such as saline for nebulizers, intravenous solutions (IV), irrigation solutions, and diluents are to be billed under medical supply items.

Dual Signature Lines

In states that have dual signature lines, signature on line stating "DAW" will not be accepted. Prescriber must write "Brand Medically Necessary" on hard copy. Prime will not accept signature on the DAW line as valid documentation.

EXTENDED SUPPLY NETWORK

Pharmacies participating in the extended supply network must maximize the Covered Person's benefit in regard to choosing between the retail benefit or Extended Supply Benefit for quantity dispensed.

GENERAL INSULIN BENEFITS

- A valid prescription must be on file for any insulin dispensed to a Covered Person
- Insulin should be dispensed within the days supply limits set by the Covered Person's Benefit Plan

Insulin Supplies

- Unless indicated by the POS system, insulin syringes and needles are generally a covered benefit
- A valid prescription is required for insulin syringes and needles that are dispensed to a Covered Person
- Some Benefit Plans will waive the Copayment for insulin supplies that are dispensed at the same time as insulin. In this situation, the insulin must be processed first

Avoid including costs for labor, equipment, professional fees or flavoring when submitting the ingredient cost.

COVERED PERSON ELIGIBILITY

A Covered Person's eligibility can be verified through the POS system during claim adjudication or by calling the Prime Contact Center. Under no circumstances should a Covered Person, whose eligibility has been verified, be denied a Prescription Drug Service (subject to Pharmacist's professional judgement) or be asked to pay more than is due under the terms of the Agreement.

Standard Eligibility Format

The eligibility format used by the majority of Prime's Benefit Sponsors includes the following elements:

- Covered Person identification (ID) number, including dependent code if applicable
- Date of birth
- Gender status
- Prescriber identifier

Some plan sponsors require additional information for processing. Please refer to the payor sheet for additional date fields.

Pharmacy shall require a person to produce a member ID card prior to providing a Prescription Drug Service. The ID card does not ensure a Covered Person's eligibility. If a Covered Person does not have a member ID card and Pharmacy is unsure of eligibility, call Prime's Contact Center to obtain accurate member information prior to processing a claim.

COVERED PERSON COMPLAINT

In the event of a dispute between Pharmacy and Covered Person, Pharmacy shall cooperate with Prime, Payor, and Benefit Sponsor in the administration and resolution of the dispute.

Pharmacy shall make a reasonable effort to resolve any oral or written complaints made by a Covered Person. Pharmacy shall keep an informal record of all events and actions taken to address the complaint and resolve the issue.

PAPER CLAIMS

Pharmacy has 90 days from the date of service to submit claims to Prime through the POS claim adjudication system.

If Pharmacy has a situation that requires the submission of a paper claim, such as Coordination of Benefits (COB), and the Benefit Sponsors' Benefit Plan allows for it, Pharmacy should submit the claim to Prime on a Universal Claim Form. Pharmacy will assume all risks including, but not limited to, eligibility, drug coverage, copayment, etc. for a paper claim.

Claims between 91-180 days old can be submitted as paper claims. Claims greater than 180 days will be denied with reject code 81 "claim too old" and should not be submitted.

Send all paper claims to:

Prime Therapeutics LLC, Attn: UCF
P.O. Box 64812
St. Paul, MN 55164-0812

The following information is required to process a paper claim. Missing or incomplete information will prevent the paper claim from being processed.

- Member name
- Member ID number
- Pharmacy NCPDP number
- Date of fill
- Prescription number
- Quantity dispensed
- Days supply
- Eleven-digit NDC number
- Compound ingredients (list NDCs of all legend drugs included in compound)
- PSC, if applicable
- Ingredient cost
- Net amount due

Dispensing Requirements and Guidelines		
Product Selection Codes		
PSC1	Physician Requested Drug Dispensed As Written	Must be written on the written prescription document by the physician, or in the case of a telephoned prescription the pharmacist must manually write on the written prescription document, "Dispense As Written". It is not acceptable to have the computer indicate a DAW 1. Also, any updates must have DAW hand written on the written prescription document. Failure to do this may result in a charge back.
PSC2	Patient Requested Drug Dispensed	If patient requests brand-name drug even though a generic is available, this needs to be noted on the written prescription document that patient requested brand. Failure to do this may result in a charge back.
PSC3	Substitution Allowed Pharmacist Select Product Dispensed	Generic pricing will apply.
PSC4	Substitution Allowed Generic Not In Stock	
PSC5	Substitution Allowed Brand Dispensed As Generic Priced As a Generic	Use when branded version of a multi-source product is dispensed as the provider's generic.
PSC6	Override	
PSC7	Substitution Not Allowed Brand Mandated By Law	Use when the law or regulations prohibit the substitution of a brand product (Orange Book States) despite the fact that generic is available.
PSC8	Substitution Allowed Generic Not Available In Marketplace	Use only in cases where generic is not available from ANY VENDOR. Will be verified in audit. Must use proper DAW Code: Could result in 100% charge back.

MAXIMUM ALLOWABLE COST (MAC) LIST

The Prime Maximum Allowable Cost (MAC) program was developed to place a specific reimbursement amount on multi-source products, both generic and brand versions.

Multiple manufacturers of a given drug product create competition in the marketplace resulting in decreased acquisition costs. Typically, generic drugs are introduced at costs ranging from 20 to 50 percent lower than those of the original brand-name product.

A number of elements support the idea of a MAC program rather than a specific percentage discount for reimbursement of multi-source products.

- Generic drugs are sold to pharmacies over a very wide discount range off AWP, whereas brand drugs are typically sold at a very narrow discount off AWP. Thus, a single discount percent off AWP does not fit all generics
- A MAC program can select a reimbursement price that will cover most generics, but not the brand version. Reimbursement lower than the brand acquisition is a strong driver to generic dispensing
- A MAC program can selectively pick generic drug products that meet pre-determined criteria relating to clinical, marketing and cost considerations

The Prime MAC program includes a list of multi-source drugs that are reimbursed at an upper limit per unit price. Highly utilized products are reviewed quarterly. However, individual products can be adjusted on an as-needed basis. If availability of a drug becomes limited, the MAC will be temporarily suspended or the drug may be permanently removed from the MAC list. The drug may be re-added when market sources confirm adequate supply and distribution.

Carefully selected, non-rated drugs may be chosen for Prime's MAC list. Elements relating to clinical and bioequivalence considerations, dosage

form, and acute vs maintenance use are especially important when reviewing unrated products. No B-rated products (where all generic sources are B-rated) are included in the Prime MAC List.

If you are a participating provider and would like access to Prime's MAC list via the Prime web site please submit the following information in an email request to:

MACAccess@PrimeTherapeutics.com

- Pharmacy/company name
- NCPDP number
- First name
- Last name
- Pharmacy phone number
- Pharmacy fax number
- Email address

After your network participation is verified, you will receive a secure user name and password via email.

A PDF file containing the Prime MAC list may also be mailed, faxed or emailed to you for a fee of $50 for each request. A signed confidentiality agreement and payment must be received before Prime's MAC list will be released.

Prime obtains pharmaceutical product information periodically from Medi-Span to update the Prime drug file. Medi-Span determines which products are considered brand-name and generic. Prime may solicit assistance from pharmacy providers when establishing a MAC list.

GENERIC DRUGS

Information about Generic Drugs

Health professionals and consumers can be assured that the FDA-approved generic drugs on the MAC list meet the same rigid standards as the brand-name drugs. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the brand-name drug
- Be identical in strength, dosage form and route of administration
- Have the same labeling
- Be bioequivalent to the referenced brand
- Meet the same batch requirements for identity, strength purity, and quality
- Be manufactured under the same strict standards of the FDA's good manufacturing practice regulations required for brand-name products

Generic Drug Standards

- Provider must dispense a generic drug whenever permitted and in accordance with applicable Laws
- Provider must use its best efforts to carry out Prime's and Plan Sponsor's 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-name medication

If you are a participating provider and would like access to Prime's MAC list via the Prime web site please submit your request to:
MACAccess@PrimeTherapeutics.com

- Provider must stock a sufficient amount of drugs under their generic name coinciding with the habits of local Prescribers, the Prime and/or local Plan Sponsor formulary(s) as indicated by the claims system response and other correspondence, or the generic formulary of the State in which the Provider resides
- When a multi-source brand medication is dispensed, Provider must submit the correct Product Selection Code (PSC) as set forth in the section entitled "Common Dispensing Errors"

PRIOR AUTHORIZATION

There are three types of prior authorization used by Prime:

1. One-time override for a dosage change, vacation, lost, spilled, or broken medication
2. Formulary Exception for Covered Persons sensitive or unresponsive to the formulary medication
3. Medications that require prior authorization by the Benefit Plan before they can be dispensed

Assignment of a prior authorization number by Prime is specific to the member's ID number and the NDC or Generic Product Indicator (GPI) of the drug.

A prior authorization number attached at the NDC level is typically a one-time override, such as a vacation request or dosage change.

A prior authorization number attached at the GPI level is typically used for a formulary exception or for a medication requiring prior authorization by the Benefit Plan. This allows the prior authorization number to override different dosage forms or strengths of the same medication. (See the Formulary Exception section on page 19.)

Pharmacy is not required to enter a prior authorization number when processing a claim. The Prime Contact Center enters prior authorization numbers into the Prime claim adjudication system. This allows the claim to process without further action by Pharmacy.

Pharmacy may obtain prior authorization for a dosage change or vacation request by calling the Prime Contact Center at **800.821.4795**.

Some Benefit Sponsors utilize an automatic override process referred to as dynamic PAs. In this situation, Pharmacy enters a pre-determined prior authorization number for certain conditions, such as a vacation request or dosage change. Pharmacy will be notified via *Prime Perspective*™ which clients allow dynamic PAs.

Some medications require a prior authorization before they will adjudicate on-line. Examples of this are Growth Hormone, Celebrex, or PPIs. These drugs will reject with a code of 76, "Step Therapy not met, PA required". Prime requires clinical documentation from the Prescribing Provider before a prior authorization will be granted. The Covered Person should contact the Covered Person service department at his or her Benefit Plan.

Obtain prior authorization for a dosage change or vacation request by calling the Prime Contact Center at **800.821.4795**.

DRUG FORMULARY

Prime manages multiple Drug Formularies for clients and administers them through the on-line POS system. The formularies are developed and approved by Pharmacy and Therapeutics (P&T) Committees, which are independent panels of physicians and pharmacists representing various practice disciplines. The P&T Committees meet no less than quarterly to review the current formularies. The results of the reviews are published in the quarterly pharmacy newsletter, *Prime Perspective*™, distributed by Prime.

When providing any Prescription Drug Service to a Covered Person, Pharmacy shall comply with the Drug Formulary.

When a non-formulary product is prescribed, and the Covered Person has a closed formulary benefit, the claim will reject with NCPDP reject code 70 "NDC Not Covered." The free-form message will indicate that the drug is non-formulary. Pharmacy should make an effort to contact the Prescribing Provider to ask if the prescription can be changed to a formulary product.

Prime also administers a three-tier copay benefit design where non-formulary drugs are covered, but Covered Persons pay a higher Copayment.

FORMULARY EXCEPTION

Prime only administers Prior Authorization (PA) programs for some of its Benefit Sponsors. Pharmacy should refer to the on-line claim messaging for additional instruction or contact information.

There are two ways to obtain a "Request for Formulary Exception" form:

1. Prescribing Providers can receive this form by contacting the provider services department at the Covered Person's Benefit Plan
2. Covered Persons can obtain this form for their Prescribing Providers by calling the member services toll-free line on the back of the member ID card

DRUG UTILIZATION REVIEW (DUR)

Prime monitors drug utilization to support your role as a professional in providing quality care to your patients.

Prime will alert Pharmacy through the on-line system in situations that include but are not limited to:

- Drug Regimen Compliance Screening
- Drug-Drug Interaction Screening
- Drug Inferred Healthstate Screening
- Dosing/Duration Screening
- Drug-Age Caution Screening
- Drug-Sex Caution Screening
- Duplicate Prescription Screening
- Duplicate Therapy Screening

Pharmacy is responsible to review any claim where there is a DUR rejection from the Prime system. Pharmacists should use their professional judgement to follow up with patients and counsel them regarding the DUR messages.

PHARMACY AUDIT

SUSPECTED FRAUD AND ABUSE

For suspected fraud or abuse by Covered Person, Prescribing Provider or Pharmacy, notify Prime , Pharmacy Compliance Officer at Prime Therapeutics LLC, P.O. Box 64182, St. Paul, MN 55164-0812 or call **800.858.0723**.

COMMON DISPENSING ERRORS

Incorrect Days Supply

Pharmacy must submit the correct days supply, based upon directions for use, to avoid an audit chargeback.

Pharmacy should submit the number of consecutive days the prescription drug will last.

Overstating the days supply may affect future refills, while understating the days supply may exceed the Covered Person's benefit.

The most common days-supply errors occur when dispensing inhalers, insulin, and medication with dosing limitations such as Larium, Fosamax and Provera. Pharmacy is responsible for submitting the correct days supply.

Example: Provera is typically prescribed to be taken for 10 consecutive days per month. In this case, 30 tablets is equal to a 90-day supply.

Example: Lariam is typically prescribed to be taken once per week. In this case, 7 tablets should be submitted as a 49-day supply.

Prescriptions written for an entire family on one prescription form should be processed as separate claims for each Covered Person.

Report suspected fraud to:

Prime Therapeutics, Pharmacy Compliance Officer
P.O. Box 64182, St. Paul, MN 55164-0812
800.858.0723

PHARMACY AUDIT

Prime conducts on-site, desk and post-payment audits. Audits are conducted in compliance with federal and state laws to assure the privacy and confidentiality of all patient records. Audits are completed to verify the integrity of claims submitted to Prime and payments to Pharmacy.

Pharmacy will provide Prime access to Pharmacy records, including invoices and prescription files, related to Prescription Drug Services provided under the Agreement. Prime will use these records to compare the on-line claims with the hard copies of prescriptions and other documentation. On-site audits will be conducted during regular business hours with prior notice to the pharmacy.

Pharmacy is required to maintain a signature log indicating that the Covered Person or designee has received the Prescription Drug Service. An electronic signature log is also acceptable.

Non-compliance with audit request is grounds for termination of the Pharmacy Participation Agreement.

No fees can be applied to Prime for time involved to perform audit. Each entity is responsible for their own expenses and provider shall bear expense of providing records required to Prime.

Auditors shall not be allowed to accept gratuities or gifts from providers.

Any provider placed on probationary or disciplinary action is required to disclose this information to Prime as soon as possible, upon investigation. This includes, but is not limited to, barring of participation in government programs, which will result in termination of contract.

Claims paid may be recovered after the government program termination date.

During the term of the agreement and for two (2) years following termination of the agreement, Prime has the right to audit compliance with this Provider Agreement for prescription claims paid to Provider by Prime. Prime has the right to inspect all records and monitor claims data for potential billing errors on a daily basis. If a discrepancy is found, an auditor will contact the Provider via fax, phone or mail to inquire about, validate and help resolve the claim(s) in question.

Most of the claims can be resolved through faxing, over the telephone, or through claim reversal and resubmission.

If a request for a hard copy is needed on claim(s) in question, the pharmacy will be asked to provide a copy. If during the daily audit review the pharmacy refuses or provides no documentation after three requests, the claim will be reversed by the Auditor.

All prescription documentation must have the full name of the Covered Person, full name of the prescribing provider, drug name, quantity and strength of the medication prescribed, specific dosage directions, and generic substitution instructions if applicable.

Prescriptions for Insulin and Diabetic Supplies must contain complete documentation of the item, quantities dispensed and directions for use. "As Directed" sigs will not be allowed. Pharmacy must obtain concise directions to accurately fill the prescription. For a drug that may be administered on a sliding scale such as Insulin, the pharmacy must obtain the dosage range. Directions may be obtained by direct communications with the prescribing provider or, if prescriber is unavailable, the Covered Person. Directions must be noted on the hard copy of the prescription.

Audits are HIPAA compliant with guidelines of disclosure for treatment, payment or health care operations. An audit cannot be denied sighting HIPAA regulations as the reason.

Daily Claims Review

Prime monitors claims data for potential billing errors on a daily basis. If a claim is in question, a pharmacy Auditor will contact the Pharmacy via fax or telephone to inquire about the validity of claims in question. Auditor will request the Pharmacy to reverse and resubmit invalid claims to resolve the discrepancy. The Pharmacy will return requested information by the dates provided; failure to do so may result in a financial penalty or termination of the Participating Pharmacy Agreement. Audits are conducted in compliance with federal and state laws to assure the privacy and confidentiality of all patients' records.

On-Site Audit

Prime performs routine on-site audits. Prime will typically notify the pharmacy approximately one to two weeks prior to a scheduled audit date. During an on-site audit, the auditors will review specific records related to claims paid to the pharmacy during the last two (2) years.

Desk Audits

During a desk audit, pharmacy is contacted via the telephone, fax or mail, and asked to provide photocopies of specific prescriptions in question related to claims paid to the pharmacy during a specified period. Documentation may include original prescriptions, signature logs, computer records, wholesaler and manufacturer invoices, and receipt of purchase for medication. Other types of desk audits include requests for information (RFI) from member complaints. Prime performs desk audits on a routine basis. The Auditor will provide a timeline of return date parameters for the Pharmacy. The Pharmacy will fax or mail hard copies of requested items at no cost to Prime. The Pharmacy will return requested information by the dates provided; failure to do so may result in financial penalty or termination of contract. Late fees may apply to any audit correspondence that is not responded to by the date stated in the audit communication.

There are several situations that could precipitate an audit:

- Referral by a Benefit Sponsor or Covered Person
- Pharmacy exceeds the normal profile in one or more audit profile categories
- Routine area audit of pharmacies in a specific geographic location

Prescription Requirements: All prescription documentation, including telephone- and computer-generated prescriptions, must contain the following information:

- Full name of Covered Person, address and date of birth for whom the prescription was written
- Full name and telephone number of the Prescribing Provider and Prescriber ID number for each claim
- Name of medication, quantity, strength of the medication prescribed, and generic substitution, if applicable
- Specific dosage directions. If directions change, a new prescription must be assigned
- If a patient requests a brand medication, DAW 2 needs to be indicated on the written prescription document
- The physician must write 'Dispense As Written' on the written prescription document, or in the case of a telephoned prescription the pharmacist must manually write on the written prescription document, "Dispensed As Written'. It is not acceptable to have the computer designate a DAW 1. Any updates must have DAW hand-written on the written prescription document. Failure to do so may result in a charge back
- Refill instructions must be documented on any change of directions. If there is a refill change a new prescription number must be generated

Compounded Prescription

Compounded prescriptions must be submitted with the most expensive drug and are reimbursed according to the Participating Pharmacy Agreement. The compound drug must contain at least one federal legend ingredient. All compound drugs must have a valid NDC number. The pharmacy must flag the claim in the system. Do not include costs for labor, equipment, professional fees, or flavoring. Syringes cannot be billed as a compound. If the physician writes a prescription for a compounded prescription and the NDC number for a brand is submitted but the compound prescription does not contain the branded product, this will result in 100 percent charge back to the pharmacy and could result in the termination of the pharmacy from the network.

"Compound Prescription" means a prescription where two or more medications are mixed together. One of these drugs must be a Federal Legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound prescription if it is reconstituted or if only water, alcohol or sodium chloride solutions are added to the active ingredient.

The following prescription types shall not be considered compounded prescriptions:

- Any prescription that includes finished products that contain the identical prescription ingredient and strength that is available commercially
- Any prescription that is sub-divided into unit dose
- Injectable prescriptions that are drawn into syringes for injection
- Any finished product that does not include a Federal Legend Drug as an ingredient
- The end product must not be available in commercial form or in therapeutic form

Time Frame

Prime reserves the right to review claims history for up to seven years. However, standard audits generally include the previous two years prior to date of audit.

Unacceptable Practices

Based on the claims submission requirements, the following are examples of unacceptable and, in some cases, fraudulent practices:

- Billing for a quantity of a legend drug that is greater than the quantity prescribed
- Billing for a higher-priced drug when a lower-priced drug was prescribed and dispensed to the Covered Person
- Dispensing a brand-name drug, billing for the generic, and then charging the Covered Person for the difference
- Billing for a legend or OTC drug without a prescription or Benefit Sponsored voucher
- Submitting a claim with a National Drug Code (NDC) other than the NDC on the package from which the drug was dispensed
- Dispensing a smaller quantity than was prescribed in order to collect more than one professional dispensing fee (prescription splitting)
- If a patient requests a smaller amount, a notation should be made on the hard copy of the prescription
- Billing more than once per month for maintenance drugs for Covered Persons in nursing facilities. A maintenance drug is a drug ordered on a regular, ongoing, scheduled basis. This limitation does not apply to treatment medications (e.g., topical preparations) or drugs ordered with a stop date of less than 30 days.

Prime may suspend or terminate the Pharmacy Participation Agreement for violations of these or other restrictions that constitute fraud or billing abuses.

Audit Resolution

Any payments made to Pharmacy that are in excess of the amount of the Pharmacy Payment under this Agreement because of error, inaccurate claims, and discrepancies to Prime's Pharmacy Provider Manual or Benefit Plans, or due to any other reason, may be recovered by Prime. Prime shall notify Pharmacy in writing of such excess payments and shall have the right either to offset such excess payment amounts against any Pharmacy Payments that may be due

to Pharmacy or to require reimbursement from Pharmacy of such excess payment amounts. If Prime requires reimbursement from Pharmacy, Pharmacy has 10 (ten) days from the date of notification to reimburse Prime any excess payment amounts. If Prime collects amounts due as a result of audit compliance, or discrepancies, Pharmacy cannot collect, seek compensation or reimbursement from, or have any recourse against a Covered Person or Benefit Sponsor in relation to any such collection.

Noncompliance

Pharmacy must provide Pharmacy Services related to a covered item to all Covered Persons. Pharmacy cannot refuse to accept a member ID card from a Covered Person. Prime considers the following acts to be serious violations and are subject to a complete bill-back of all fees: failing to submit a claim for a covered item for a Covered Person or submitting the incorrect data for a claim or claims, collecting an amount different than displayed in the claims system, submitting the incorrect data for the DAW code, submitting inaccurate usual and customary code (U&C) price. If Pharmacy is banned from the government due to an OIG Investigation, Pharmacy is subject to termination and must immediately notify Prime. All claims will be subject to a bill-back. Pharmacy and Pharmacist must notify Prime immediately of any disciplinary action from an OIG Investigation.

Fees for Noncompliance

Fees will be calculated based on errors or noncompliance with audit request. Prime reserves the right to apply late fees to audit recoveries that are not collected by the due date.

Disciplinary Actions

If Pharmacy is found to be in violation of billing processes according to their contract with Prime, Pharmacy will be subject to termination from the Prime Networks. This action may be appealed by Pharmacy and in all cases will be reviewed by the director of pharmacy services. A Pharmacy that has been suspended may request to be reinstated into the Prime Network after a one-year suspension. Pharmacies that are found to have minor violations may be put on a one-year probationary status whereby their billing profile is monitored at six-month intervals. At the end of a one-year period if the pharmacy has corrected the billing problems and if no other issues arise, the pharmacy will be released from the probationary status. If, during an audit, the Prime Auditor has uncovered violations by a Covered Person or Prescribing Provider, a report detailing the infractions will be sent to the fraud department of the Benefit Sponsor.

Rights Upon Termination

In the event of a termination or expiration of the Participating Pharmacy Agreement, the termination or expiration shall be deemed to end only the term of this Agreement, and the respective parties shall

continue to be obligated by this Agreement to conclude and terminate their affairs in an orderly fashion, to make and perform any accounting required hereunder, or undertake within two (2) years after such termination or expiration (at Prime's option) any audits permitted hereunder, to settle their mutual accounts, to resolve any disputes between themselves or with Covered Persons, to commence, continue and complete any surveys and inspections permitted hereunder relating to the monitoring and reporting of the quality, utilization and accessibility of Prescription Drug Services, to maintain the confidentiality of information in accordance with this Agreement, and to honor provisions herein regarding indemnification for acts and omissions occurring prior to the effective date of such expiration or termination.

ARBITRATION

In the event that a dispute arises in relation to the Agreement, the parties will meet and negotiate in good faith to solve the dispute. If the dispute cannot be resolved within 30 days, and one of the parties wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules and procedures of the American Arbitration Association.

INSPECTION OF RECORDS AND AUDIT

Maintenance of Records

Pharmacy shall maintain records that comply with state and federal law, rules and regulations of Prescription Drug Services provided to Covered Persons under this Agreement for seven (7) years after the date such Prescription Drug Services were provided, or such longer time as required by applicable law. Such records shall be in a format deemed appropriate by Pharmacy, or as otherwise required by applicable law.

Inspection Rights

During the term of agreement and for two (2) years following termination of the agreement for any reason, Prime has the right to inspect all records of the pharmacy and go back seven (7) years of claims that were mis-billed and submitted to Prime. Refusal of an audit is subject to immediate termination. However, standard audits generally include the previous two (2) years prior to date of audit.

Prime has the right to submit claims for rebate programs.

Compliance Investigations

Prime conducts many types of audit services related to Pharmacy's performance of the Agreement, including but not limited to, concurrent DUR audits and retrospective audits in the form of telephone inquiry, investigational desk audits, or on-site field audits. Pharmacy shall cooperate in all audit programs and processes, including telephonic, facsimile, mail, internet, on-line claims system, and in person, conducted by Prime in performance of this Agreement.

Access to Pharmacy Records by Prime

Pharmacy agrees that Prime or any auditor designated by Prime may, upon request, during normal business hours, examine and reproduce Pharmacy's records including, but not limited to, original prescriptions, signature logs, daily prescription logs, purchasing invoices, refill information, Prescribing Provider information, patient profiles and prescription inventory related to Prescription Drug Services provided by Pharmacy under this Agreement. All such audits will be conducted in compliance with federal and state laws governing the right of privacy and the confidentiality of Protected Health Information (PHI). If Pharmacy fails to comply with this Section, Prime shall have the right to withhold Pharmacy Payments to Pharmacy for Prescription Drug Services provided by Pharmacy until Pharmacy corrects such failure by fully complying with this Section and Prime has finalized its review of the requested information and records or copies of records.

Privacy of Covered Person Information

The parties shall maintain the confidentiality of any information relating to Covered Persons in accordance with applicable laws and regulations including, but not limited to, HIPAA. It is contemplated by this Agreement that confidential information, including PHI, about Covered Persons will be obtained by Prime and by Pharmacy in providing services under this Agreement and that such confidential information will be obtained from and/or distributed to Benefit Sponsors, Prime, Pharmacy and Covered Persons' physicians for drug utilization evaluation, claims processing and other purposes relating to the Benefit Plan. Such exchange of confidential information shall be made in accordance with applicable laws and regulations. The terms of this Section shall survive the termination of this Agreement.

Confidential Business Information

Prime and Pharmacy shall take all necessary steps to provide maximum protection to the other party's trade secrets and other confidential business information. Such information shall not be disclosed to third parties without the express written consent of the party to whom the information belongs, unless such disclosure is required to comply with any law or is expressly permitted by this Agreement.

Compliance with Laws and Regulations

The federal, state and local governments and any of their authorized representatives shall have access to, and Prime, Payor and Benefit Sponsor are authorized to release, in accordance with applicable laws and regulations, all information and records, or copies of such, within the possession of Prime, Payor, Benefit Sponsor or Pharmacy, which are pertinent to and involve transactions related to this Agreement and access to which is necessary to comply with laws and regulations applicable to Prime, Payor or Benefit Sponsor.

Distributor and Manufacturer Invoices

Wholesalers' and manufacturers' invoices must be maintained for two (2) years. To substantiate that the drugs dispensed were purchased from an authorized source, Prime may request that the pharmacy give authorization to the wholesaler or manufacturer to release invoices for purchase verification. The pharmacy must promptly comply with such requests. If the pharmacy fails to provide authorization Prime has the right to charge back 100 percent of the amount paid for any claims in question.

CONFIDENTIALITY AND PROPRIETARY RIGHTS

Confidentiality

Any information (including, but not limited to, products, programs, services, business practices, procedures, MAC lists, or other information acquired from the contents of the Provider Agreement, Provider Manual, or other Prime Documents) or data obtained from or provided by Prime or any Plan Sponsor to Provider is confidential and must be maintained in confidence and may not be sold, assigned, transferred or given to any third party. Any such information or data may be disclosed to employees, agents, or contractors of Providers only to the extent necessary for said parties to perform their duties and then only if they have undertaken like obligations of confidentiality.

- No information or data obtained from or provided by Prime to Provider may be quoted or attributed to Provider or Prime without the prior written consent of Prime
- Prime and Provider must use all necessary security procedures to ensure that all information and data exchanges are authorized, and to protect any information or data records from improper access
- Provider must maintain the confidentiality of an Eligible Person's personal profile and records as required by applicable Law. Provider may not use the information provided by Eligible Persons for any purpose not related to the Agreement, except to the extent such use is in accordance with applicable Law
- Provider must promptly notify Prime if it becomes aware of any unauthorized use of confidential information or data.

Proprietary Rights

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

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

Prime has 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.

Remedies

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

Accordingly, if Provider should fail to abide by the provision and terms set forth in this Section of the Pharmacy Provider Manual, Prime will be entitled to 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, and to all other remedies provided by the Provider Agreement and applicable Law.

HIPAA LAWS: PERMITTED USES AND DISCLOSURES

A Covered Entity May Disclose PHI:

- To the individual
- For treatment, payment or health care operations
- Incident to a use or disclosure permitted by the rule if appropriate safeguards are in place, e.g., accidental disclosure to a building maintenance worker
- Pursuant to an authorization
- Pursuant to an agreement, such as for use in a facility directory or for notification of persons involved in the care of an individual
- When required by law
- For public health activities when required by a public health authority
- When covered entity believes there are victims of abuse, neglect or domestic violence
- For health oversight activities
- For judicial or administrative proceedings
- For law enforcement purposes
- To coroners or funeral directors about a decedent
- For a cadaveric organ, eye or tissue donation purpose
- For permitted research purposes
- To avert a serious threat to health or safety
- For specialized government functions, such as veterans activities or national security
- For workers compensation purposes

OBLIGATIONS OF THE PHARMACY

Terms and Conditions

In addition to the other terms and conditions of the Participating Provider Agreement, the following provisions shall apply to any services provided under the Agreement in connection with the Medicare Advantage Program, the Medicare Part D Program, or other CMS Medicare programs, as defined below (collectively, the "Medicare Programs"). In the event that there is any conflict between the Exhibit C and the Agreement, with regard to services for the Medicare Programs, the Exhibit shall control.

Record Retention and Right to Inspect

Subject to the Freedom of Information Act (FOIA) or HIPAA, at no charge to Prime or Benefit Sponsors, Pharmacy shall retain and agrees that Prime, Benefit Sponsor, HHS, the Comptroller General of the U.S. Government Accountability Office or their designees shall have the right to audit, evaluate and inspect, any pertinent books, contracts, medical records, patient care documentation and any other documents related to the Agreement or as each may deem necessary to enforce the Agreement or its contract between or with any of the others. Such obligation to retain and right to inspect, evaluate and audit such pertinent information shall extend for a period of 10 (ten) years following the date of service, last date of the Agreement, or until the completion of the audit, whichever is later unless the time frame is extended for reasons specified by regulation or as provided below. Pharmacy agrees to make available, for the purposes specified in this Section, its physical facilities and equipment, all records relating to Subscribers, and any additional relevant information that Prime, Benefit Sponsor, CMS, the Comptroller General, or their designees may require. The terms of this Section shall survive the termination of the Agreement.

If Prime or Benefit Sponsor notifies Pharmacy that CMS has determined that there is a special need to retain a particular record or group of records for a longer period of time, Pharmacy shall comply with CMS's determination.

If there has been a termination, dispute, or allegation of fraud or similar fault by Pharmacy, Prime or Benefit Sponsor, the obligation in this Section 3 shall be extended to 10 (ten) years from the date of any resulting final resolution of the termination, dispute, fraud or similar fault.

If CMS determines that there is a reasonable possibility of fraud or similar fault on the part of Pharmacy, Prime or Benefit Sponsor, CMS may inspect, evaluate and audit the records of Pharmacy at any time.

Confidentiality and Enrollee Record Requirements

Pharmacy shall maintain any health or enrollment information regarding Subscribers in an accurate and timely manner and shall provide timely access by the Subscribers to the records and information that pertains to them. Pharmacy shall safeguard the privacy of the information that identifies a particular Subscriber and shall abide by all applicable federal and state law or regulation regarding such confidentiality including, without limitation, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, and 42 C.F.R. § 423.136. Pharmacy shall release such information only in accordance with Prime policies and procedures, applicable federal or state law, or as required pursuant to valid court orders or subpoenas.

Prompt Payment

Prime shall pay Pharmacy for Covered Services rendered to Subscribers in accordance with the applicable Exhibit B, Prime Medicare Network(s) Rate and Terms Exhibit, to the Agreement. Any clean claim, as defined in 42 C.F.R. 422.500 shall be paid within 30 (thirty) days of receipt by Prime at such address as may be designated by Prime, and Prime shall pay interest on any clean claim not paid within the stated time period.

Copayments

Pharmacy shall charge Subscribers only the applicable Copayment pursuant to Subscriber's Benefit Plan. In determining the applicable Copayment, Pharmacy shall take into account any subsidy for which the Subscriber is eligible under 42 C.F.R.§§ 423.771 to 423.800.

Access to Negotiated Prices

Pharmacy shall provide Subscribers access to negotiated prices for all drugs on the Drug Formulary, even when Subscriber is not entitled to any benefit under the terms of the Benefit Plan under the Medicare Programs.

Hold Harmless

Pharmacy agrees that in no event including, but not limited to, non-payment by Prime, a Benefit Sponsor insolvency of Prime or Benefit Sponsor or breach of the Agreement, shall Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Subscribers or persons other than Prime acting on their behalf for Covered Services. In the event that an audit or investigation reveals that a Subscriber has been charged for such amounts, such amounts shall be promptly refunded to Subscriber by Pharmacy or, in the sole discretion of Pharmacy, credited against amounts due to Pharmacy from Subscriber. This provision shall not prohibit collection of Copayments.

Pharmacy further agrees that (i) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Subscriber; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Pharmacy and the Subscriber or persons acting on their behalf.

Continuation of Benefits

Notwithstanding Article 6 of the Agreement, Pharmacy shall continue to provide services to Subscribers for the duration of the applicable contract between CMS and the respective Benefit Sponsors, and with respect to Subscribers who are hospitalized on the date that the applicable Benefit Sponsor's agreement with CMS terminates or expires, or if the Benefit Sponsor becomes insolvent, through the date of such Subscriber's discharge.

Compliance with Federal and State Laws

Pharmacy shall comply with all laws applicable to individuals and entities receiving federal funds and all other applicable Federal and State laws and regulations and governmental issuances including, but not limited to, the Social Security Act, the regulations governing participation in the Medicare Programs, all CMS guidance and instructions, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973. Pharmacy represents and warrants that it will contractually obligate any third-party contractor or service provider to comply with all relevant laws, regulations and CMS instructions.

Exclusion of Certain Persons

Pharmacy hereby represents and warrants that Pharmacy does not currently, and shall not in the future, employ or contract with any individual excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with any entity that employs or contracts with such an individual for the performance of any of its responsibilities under the Agreement.

Monitoring and Approval Rights

Pharmacy acknowledges and agrees that Prime and each Benefit Sponsor under the Medicare Advantage Program or the Medicare Part D Program are responsible to CMS for the composition of its pharmacy network and that Prime and each such Benefit Sponsor shall monitor the performance of Pharmacy under the Participating Provider Agreement, that Pharmacy shall perform its obligations under the Agreement consistent with Benefit Sponsor's contract with CMS, and that each Benefit Sponsor retains the right at its own discretion or as directed by CMS, to approve, suspend or terminate the Agreement as it relates to that Benefit Plan.

Data Collection Requirements

Pharmacy acknowledges that Prime or Benefit Sponsor is required by CMS to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality. Pharmacy shall submit to Prime or Prime's designee, in the form and within the time frames prescribed by Prime, all risk adjustment and encounter data as may be required for Prime to fulfill its obligations to Benefit Sponsors. Prime reserves the right, upon notice to Pharmacy, to adopt a schedule of financial penalties to be imposed on Pharmacy at Prime's option for failure to submit complete and accurate data.

Price Disclosure Obligations of Pharmacy

Pharmacy shall inform a Subscriber, upon request, at the time of delivery of the drug (i) of any differential between the discounted ingredient cost plus dispensing fee of the Covered Service, and (ii) the price of the lowest-priced generic alternative available (not limited to those generics on the Drug Formulary) that is therapeutically equivalent and bioequivalent, and available at the Pharmacy. Pharmacy shall also inform Benefit Sponsor of the lowest-priced, generically equivalent drug, if one exists for the Subscriber's Benefit Plan, as well as any associated differential in price.

Real-Time Adjudication

Pharmacy shall use a real-time POS claims adjudication system, as specified by Prime.

Subcontractors

To the extent that Pharmacy contracts with a subcontractor to perform any of its obligations under the Agreement, Pharmacy shall contractually bind such subcontractor to perform its obligations in a manner consistent with the Agreement.

Delegation of Duties

The parties hereto acknowledge that Prime oversees and is accountable to the Benefit Sponsor and CMS for certain functions and responsibilities described in the Medicare Programs, as applicable. In the event that Prime delegates to Pharmacy any function or responsibility imposed pursuant to Prime's Medicare

Programs contract(s) with Benefit Sponsor, such delegation shall be subject to the regulations governing participation in such Medicare Programs, including all CMS guidance and instructions.

Minimum Standards

Pharmacy agrees to comply with the minimum performance and service criteria contained in the Exhibit C, if applicable, to the Agreement.

MEDICARE CLAIMS PROCESSING

Claims Processing Procedure

Additional processing information for the Medicare program will be sent to all Prime network pharmacies prior to January 1, 2006.

Covered Items

In general, the following items are covered under the Medicare Part D prescription drug benefit:

- Prescription drugs
- Biological products
- Certain vaccines
- Insulin
- Diabetic medical supplies

Exclusions

In general, the following items are excluded from coverage under the Medicare Part D prescription drug benefit. Pharmacies should rely on the POS processing system for accurate benefit information.

- Barbiturates
- Benzodiazipines
- OTCs (except insulin)
- Infertility drugs (and infertility injectables)
- Legend oral vitamins
- Anorexients/weight loss drugs
- Medications for cosmetic purposes

Benefits and Covered Person Cost Share

In general, the Medicare benefit will include the following:

- Two-or three-tier copay
- Deductible may apply (not to exceed $250)
- Coverage to $2,250 (subject to cost share)
- Covered Person pays 100% from $2,251 to $5,100 – coverage gap
- $5,100 and up – 95% coverage

Coordination of Benefits (COB)

Beginning January 1, 2006, COB claims can be processed on Prime's claims processing system. To process a COB claim, the COB segment in the claim processing system must be filled out by the pharmacy. This is part of the standard 5.1 claims processing layout. Additional information can be found on the Prime Payor sheet, which can be located at **www.primetherapeutics.com/pharmacist/payorsheet.**

On-line COB capabilities will be available for Medicare claims only starting January 1, 2006. Claims for all other clients should use the paper claim process stated in this manual. Additional processing information will be sent to pharmacies prior to the Medicare implementation date.

The following NCPDP fields must be populated to process a COB claim:	
308-C8	Other coverage Code
337-4C	Coordination of Benefits/ Other Payment Count
338-5C	Other Coverage Payor Type
339-6C	Other Payor ID Qualifier
340-7C	Other Payor ID
431-DV	Other Payor Amount Paid
443-E8	Other Payor Date

Quantity Limits

The following medications may have quantity limit restrictions under the Medicare Part D program: Cholesterol medications, Proton-Pump Inhibitors, Oxycontin, ketorolac, Celebrex, Migraine medications, Asthma medications, Bisphosphonate, Allergy medications, Erectile Dysfunction medications, and Urinary Incontinence medications.

Prior Authorization

The following medications may require Prior Authorization under the Medicare Part D program: Regranex, Xolair, Epogen, Progrit, Aranesp, GCSF Agents, Hepatitis C agents, and Forteo.

Step Therapy

The following medications may be part of a step therapy program under the Medicare Part D program: Zetia, Angiotensin Converting Enzyme Inhibitors and Angiotension II Receptor Antagonists, Proton-Pump Inhibitors, Actos, Avandia, Depression medications, Leukotriene, Enbrel, Humira and Kineret, Amevive and Raptiva, Epilepsy medications, and Atopic dermatitis medications.

Medication Therapy Management

The Medicare prescription drug benefit provided through Prime will include Medication Therapy Management. Additional information will be sent to pharmacies regarding this program prior to the implementation date.

MEDICARE TRANSITION PROCESS AND LONG TERM CARE

Transition Process

Prime's general transition process will help ensure that Medicare beneficiaries experience a seamless bridge between prescription drug plans and medications where appropriate. Prime will educate pharmacies using standard industry practices, including email and hard copy mailings of information related to the transition process. This information will be sent to pharmacies prior to the implementation date. Information will also be available on the Prime web site at **www.primetherapeutics.com.**

Locate the Prime Payor Sheet at:
www.primetherapeutics.com/pharmacist/payorsheet

A transition process will also be implemented for Medicare beneficiaries currently living in Long Term Care Facilities or receiving medications from Long Term Care pharmacies. This process will allow for medications that are not on the Part D formulary but are required in the medical management for beneficiaries. This information will be sent to pharmacies prior to the implementation date.

LONG TERM CARE GUIDELINES AND PROCEDURES

Pharmacies that provide services to nursing home patients should be familiar with the following guidelines:

- Claims should be billed no more than once per month
- Seven-day unit packages should be logged and billed no more than once per month
- OTC products should be dispensed in the original container
- In no event may the OTC product be priced higher than the shelf price
- Items that are normally supplied by the nursing home on a per-diem basis, such as test strips and syringes, should not be billed to Prime

Unique dispensing methods such as tray changes every two days or every seven days do not justify additional fees. One fee per month is reimbursable even when the product is delivered to a nursing home one tablet at a time.

MINIMUM PERFORMANCE AND SERVICE CRITERIA

The Minimum Performance and Service Criteria apply to any Pharmacy that provides Prescription Drug Services to Enrollees of Medicare Programs or Covered Persons that are residents of long-term care facilities or receive services from long-term care pharmacies or facilities.

Comprehensive Inventory and Inventory Capacity

Pharmacy must provide a comprehensive inventory of Plan formulary drugs commonly used in the long-term care setting. In addition, Pharmacy must provide a secured area for physical storage of drugs, with necessary added security as required by federal and state law for controlled substances. Pharmacy does not have to maintain inventory or security measures outside of the normal business setting.

Pharmacy Operations and Prescription Orders

Pharmacy must provide services of a dispensing pharmacist to meet the requirements of pharmacy practice for dispensing prescription drugs to long-term care (LTC) residents including, but not limited to, the performance of drug utilization review (DUR). In addition, the pharmacist employed by Pharmacy must conduct DUR to routinely screen for allergies and drug interactions, to identify potential adverse drug reactions, to identify inappropriate drug usage in the LTC population, and to promote cost effective therapy in the LTC setting. Pharmacy must

also be equipped with pharmacy software and systems sufficient to meet the needs of prescription drug ordering and distribution to a LTC facility. Pharmacy must provide written copies of its pharmacy procedures manual and said manual must be available at each LTC facility nurses' unit. Pharmacy must also provide ongoing in-service training to assure that LTC facility staff are proficient in Pharmacy's processes for ordering and receiving medications. Pharmacy must be responsible for return and/or disposal of unused medications following discontinuance, transfer, discharge, or death as permitted by State Boards of Pharmacy. Controlled substances and out of date substances must be disposed of within state and federal guidelines.

Special Packaging

Pharmacy must have the capacity to provide specific drugs in Unit of Use Packaging, Bingo Cards, Cassettes, Unit Dose or other special packaging commonly required by LTC facilities. Pharmacy must have access to, or arrangements with, a vendor to furnish supplies and equipment including, but not limited to, labels, auxiliary labels, and packing machines for furnishing drugs in such special packaging required by the LTC setting.

IV Medications

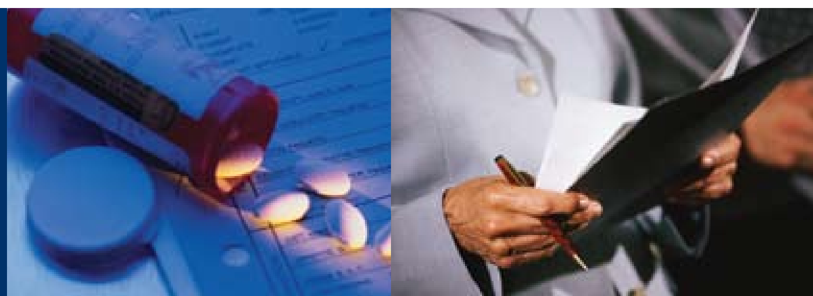
Pharmacy must have the capacity to provide IV medications to the LTC resident as ordered by a qualified medical professional. Pharmacy must have access to specialized facilities for the preparation of IV prescriptions (clean room). Additionally, Pharmacy must have access to, or arrangements with, a vendor to furnish special equipment and supplies as well as IV trained pharmacists and technicians as required to safely provide IV medications.

Compounding/Alternative Forms of Drug Composition

Pharmacy must be capable of providing specialized drug delivery formulations as required for some LTC residents. Specifically, residents unable to swallow or ingest medications through normal routes may require tablets to be split or crushed or provided in suspensions or gel forms to facilitate effective drug delivery.

Pharmacist On-call Service

Pharmacy must provide on-call, 24 hours a day, 7 days a week service with a qualified pharmacist available for handling calls after hours and to provide medication dispensing available for emergencies, holiday and after hours of normal operations.



Delivery Service

Pharmacy must provide for delivery of medications to the LTC facility up to 7 days each week (up to 3 times per day) and between regularly scheduled visits. Emergency delivery service must be available 24 hours a day, 7 days a week. Specific delivery arrangements will be determined through an agreement between Pharmacy and the LTC facility. Pharmacy must provide safe and secure exchange systems for delivery of medication to the LTC facility. In addition, Pharmacy must provide medication cassettes, or other standard delivery systems, that may be exchanged on a routine basis for automatic restocking. Pharmacy delivery of medication to carts is a part of routine "dispensing."

Emergency Boxes

Pharmacy must provide "emergency" supply of medications as required by the facility in compliance with state requirements.

Emergency Log Books

Pharmacy must provide a system for logging and charging medication used for emergency/first dose stock. Pharmacy must maintain a comprehensive record of a resident's medication order and drug administration.

Miscellaneous Reports, Forms and Prescription Ordering Supplies

Pharmacy must provide reports, forms and prescription ordering supplies necessary for the delivery of quality pharmacy care in the LTC setting. Such reports, forms and prescription ordering supplies may include, but will not necessarily be limited to, provider order forms, monthly management reports to assist the LTC facility in managing orders, medication administration records, treatment administration records, interim order forms for new prescription orders, and boxes/folders for order storage and reconciliation in the facility.

CHARGES

Research Fee

$65 per hour
(research for claim or remittance information in excess of two hours)

Remittance Request

$50 each
(Remit or CD/DVD recreate)

MAC Request

$50 each

Application Fee

Prime reserves the right to charge an application fee to pharmacies.

DEFINITIONS

Agreement	The Pharmacy Agreement between Pharmacy and Prime.
Ancillary Charge	A charge in addition to the Copayment that the Covered Person is required to pay to a Pharmacy for Prescription Drug Services. The Ancillary Charge is assessed when the Prescribing Provider or Covered Person has requested a drug that is not on the Drug Formulary or the MAC list.
Average Wholesale Price (AWP)	"Average Wholesale Price" or "AWP" means the average wholesale price of a Prescription Drug Service at the time a claim is processed as established in the Prime price file and updated no less than weekly by Medi-Span or by such other national drug database as Prime may solely designate.
Benefit Plan	Any health care plan, program, group or individual plan policy, agreement or other arrangement sponsored, issued or administered by a Benefit Sponsor, which includes outpatient pharmaceutical services or benefits, or access to pricing under this Agreement in accordance with the terms of the Benefit Plan, including, but not limited to, plans approved by CMS under the Medicare Part D Program.
Benefit Sponsor	An entity which sponsors, issues or administers a Benefit Plan and has agreed with Prime to use a Prime-administered network to process and adjudicate the Prescription Drug Service.
Claims Data Ownership	Prime shall be the sole owner of the information obtained through the administration and processing of Prescription Drug Services it receives pursuant to this Agreement.
CMS	The Center for Medicare and Medicaid Services.
Compound Prescription	A prescription where two or more medications are mixed together. One of these drugs must be a Federal Legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound prescription if it is reconstituted or if only water, alcohol or sodium chloride solutions are added to the active ingredient.

Copayment

The amount a Covered Person is required to pay under the Benefit Plan for the Prescription Drug Service, and shall include applicable deductibles, coinsurance, payments made by a Subscriber for covered drugs under the Medicare Part D Program after exhausting the Medicare Part D initial coverage limit, or ancillary charges.

Covered Person

A person who is properly enrolled in or covered by a Benefit Plan and entitled to obtain a Prescription Drug Service at the time a prescription is dispensed. This includes a Subscriber under the Medicare Part D Program.

Drug Formulary

A document or documents listing various pharmaceutical products that are provided to Pharmacies, Covered Persons, physicians or other health care providers for the purpose of guiding the prescribing and dispensing of pharmaceutical products. The drug formulary may be amended from time to time by Prime or a Benefit Sponsor.

Drug Manufacturer

Prime shall have the right to submit all claims relating to Prescription Drug Services provided under this Agreement to pharmaceutical drug manufacturers. Pharmacy shall not submit any of the claims relating to Prescription Drug Services provided under this Agreement to any drug manufacturer's discount or purchasing program, except as authorized by Prime in writing.

Federal Legend Drug

A drug that is required by law to bear on its packaging, 'Caution: Federal law prohibits dispensing without a prescription' or 'Rx Only'.

HHS

The United States Department of Health and Human Services.

Maximum Allowable Cost (MAC)

The list delineating the maximum per unit reimbursement as established and solely determined by Prime for a multiple source prescription drug, medical product or device at the time a claim is processed. The MAC is subject to review and modification by Prime in its sole discretion.

Medicare Advantage Program

The program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act.

Medicare Part D Program	The program created by Congress in the Medicare Modernization Act of 2003 that created the Medicare Part D prescription drug benefit program under Part D of Title XVIII of the Social Security Act.
Pharmacy Provider Manual	The manual published by Prime to explain procedures to be used by Pharmacies in connection with the pharmacy agreement. Pharmacy agrees to fully comply with all terms, provisions, conditions and limitations set forth in the Provider Manual. It may be updated from time to time.
Payor	The entity who is financially responsible for payment of a Prescription Drug Service. A Benefit Sponsor or Covered Person or both may be the Payor.
Pharmacy	A pharmacy, including Pharmacy, or a medical provider legally authorized to provide Prescription Drug Services and which has entered into an agreement with Prime to provide Prescription Drug Services to a Covered Person.
Pharmacy Payment	The amount payable to the Pharmacy under the terms of the Agreement.
Point of Sale (POS)	The method of submitting claims on-line through an automated claim adjudication process, which includes interactive communications between a terminal located at a Pharmacy and a claims processor designated by Prime or a Benefit Sponsor.
Prescribing Provider	A Doctor of Medicine or other health care professional who is duly licensed and qualified under the laws of the jurisdiction in which Prescription Drug Services are received and may in the usual course of his or her practice, legally prescribe Prescription Drug Services for Covered Persons.
Prescription Drug Service	An outpatient drug product, item or service that is covered under a Covered Person's Benefit Plan and is provided to a Covered Person pursuant to a prescription issued by a Prescribing Provider in accordance with the Pharmacy Agreement.

Signature Logs

Pharmacy shall maintain a signature log at each pharmacy location or other evidence specifically approved by Prime for each Prescription Drug Service dispensed to a Covered Person, which acknowledges receipt of the Prescription Drug Service. Each Covered Person (or his or her authorized agent) who receives a Prescription Drug Service shall be required to sign the log, acknowledging the date the Prescription Drug Service was received and the prescription number. Electronic prescription must have provisions for documenting receipt of the prescription authorized by both pharmacy and patient.

Subscriber

A person who is eligible for benefits under the Medicare Part D Program and who is enrolled in a Benefit Plan.

Usual and Customary Charge (U&C)

The lowest price Pharmacy would charge to a particular customer if such customer were paying cash for the identical Prescription Drug Services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts and other special discounts offered to attract customers. A pharmacy cannot have a U&C for prescription drug programs that differs from either cash customers or other third-party programs. Pharmacy must submit the accurate U&C Charge with respect to all claims for Prescription Drug Services.

Wholesale Acquisition Cost

The wholesale acquisition cost of a Prescription Drug Service at the time a claim is processed as established in the Prime price file and updated no less than twice monthly by Medi-Span or by such other national drug database as Prime may solely designate.

NCPDP TELECOMMUNICATION REJECT CODES

REJECT CODES FOR TELECOMMUNICATION STANDARD

Reject Code	Explanation	Field Number Possibly In Error
00	(“M/I” Means Missing/Invalid)	
01	M/I Bin Number	101
02	M/I Version/Release Number	102
03	M/I Transaction Code	103
04	M/I Processor Control Number	104
05	M/I Service/Provider Number	201
06	M/I Group ID	301
07	M/I Cardholder ID	302
08	M/I Person Code	303
09	M/I Date Of Birth	304
1C	M/I Smoker/Non-Smoker Code	334
1E	M/I Prescriber Location Code	467
10	M/I Patient Gender Code	305
11	M/I Patient Relationship Code	306
12	M/I Patient Location	307
13	M/I Other Coverage Cod	308
14	M/I Eligibility Clarification Code	309
15	M/I Date of Service	401
16	M/I Prescription/Service Reference Number	402
17	M/I Fill Number	403
19	M/I Days Supply	405
2C	M/I Pregnancy Indicator	335
2E	M/I Primary Care Provider ID Qualifier	468
20	M/I Compound Code	406
21	M/I Product/Service ID	407
22	M/I Dispense As Written (DAW)/ Product Selection Code	408
23	M/I Ingredient Cost Submitted	409
25	M/I Prescriber ID	411
26	M/I Unit Of Measure	600
28	M/I Date Prescription Written	414
29	M/I Number Of Refills Authorized	415
3A	M/I Request Type	498-PA
3B	M/I Request Period Date-Begin	498-PB
3C	M/I Request Period Date-End	498-PC
3D	M/I Basis Of Request	498-PD

Reject Code	Explanation	Field Number Possibly In Error
3E	M/I Authorized Representative First Name	498-PE
3F	M/I Authorized Representative Last Name	498-PF
3G	M/I Authorized Representative Street Address	498-PG
3H	M/I Authorized Representative City Address	498-PH
3J	M/I Authorized Representative State/Province Address	498-PJ
3K	M/I Authorized Representative Zip/ Postal Zone	498-PK
3M	M/I Prescriber Phone Number	498-PM
3N	M/I Prior Authorized Number-Assigned	498-PY
3P	M/I Authorization Number	503
3R	Prior Authorization Not Required	407
3S	M/I Prior Authorization Supporting Documentation	498-PP
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization	
3W	Prior Authorization In Process	
3X	Authorization Number Not Found	503
3Y	Prior Authorization Denied	
32	M/I Level Of Service	418
33	M/I Prescription Origin Code	419
34	M/I Submission Clarification Code	420
35	M/I Primary Care Provider ID	421
38	M/I Basis Of Cost Determination	423
39	M/I Diagnosis Code	424
4C	M/I Coordination Of Benefits/Other Payments Count	337
4E	M/I Primary Care Provider Last Name	570
4W	Must Fill Through Specialty Pharmacy	407, 489
40	Pharmacy Not Contracted With Plan On Date Of Service	None
41	Submit Bill To Other Processor Or Primary Payor	None

Reject Code	Explanation	Field Number Possibly In Error
5C	M/I Other Payor Coverage Type	338
5E	M/I Other Payor Reject Count	471
50	Non-Matched Pharmacy Number	201
51	Non-Matched Group ID	301
52	Non-Matched Cardholder ID	302
53	Non-Matched Person Code	303
54	Non-Matched Product/Service ID Number	407
55	Non-Matched Product Package Size	407
56	Non-Matched Prescriber ID	411
58	Non-Matched Primary Prescriber	421
6C	M/I Other Payor ID Qualifier	339
6E	M/I Other Payor Reject Code	472
60	Product/Service Not Covered For Patient Age	302, 304, 401, 407
61	Product/Service Not Covered For Patient Gender	302, 305, 407
62	Patient/Card Holder ID Name Mismatch	310, 311, 312, 313, 302
63	Institutionalized Patient Product/ Service ID Not Covered	
64	Claim Submitted Does Not Match Prior Authorization	201, 401, 404, 407, 416
65	Patient Is Not Covered	303, 306
66	Patient Age Exceeds Maximum Age	303, 304, 306
67	Filled Before Coverage Effective	401
68	Filled After Coverage Expired	401
69	Filled After Coverage Terminated	401
7C	M/I Other Payor ID	340
7E	M/I DUR/PPS Code Counter	473
70	Product/Service Not Covered	407, 498
71	Prescriber Is Not Covered	411
72	Primary Prescriber Is Not Covered	421
73	Refills Are Not Covered	402, 403
74	Other Carrier Payment Meets Or Exceeds Payable	409, 410, 442
75	Prior Authorization Required	462
76	Plan Limitations Exceeded	405, 442
77	Discontinued Product/Service ID Number	407
78	Cost Exceeds Maximum	407, 409, 410, 442
79	Refill Too Soon	401, 403, 405
8C	M/I Facility ID	336

Reject Code	Explanation	Field Number Possibly In Error
8E	M/I DUR/PPS Level Of Effort	474
80	Drug-Diagnosis Mismatch	407, 424
81	Claim Too Old	401
82	Claim Is Post-Dated	401
83	Duplicate Paid/Captured Claim	201, 401, 402, 403, 407
84	Claim Has Not Been Paid/Captured	201, 401, 402
85	Claim Not Processed None	
86	Submit Manual Reversal None	
87	Reversal Not Processed None	
88	DUR Reject Error	
89	Rejected Claim Fees Paid	
90	Host Hung Up Host Disconnected Before Session Completed	
91	Host Response Error Response Not In Appropriate Format To Be Displayed	
92	System Unavailable/Host Unavailable Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period	
*95	Time Out	
*96	Scheduled Downtime	
*97	Payor Unavailable	
*98	Connection To Payor Is Down	
99	Host Processing Error Do Not Retransmit Claim(s)	
AA	Patient Spenddown Not Met	
AB	Date Written Is After Date Filled	
AC	Product Not Covered Non-Participating Manufacturer	
AD	Billing Provider Not Eligible To Bill This Claim Type	
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare	
AF	Patient Enrolled Under Managed Care	
AG	Days Supply Limitation For Product/ Service	
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients	
AJ	Generic Drug Required	
AK	M/I Software Vendor/Certification ID	110
AM	M/I Segment Identification	111
A9	M/I Transaction Count	109

Reject Code	Explanation	Field Number Possibly In Error
BE	M/I Professional Service Fee Submitted	477
B2	M/I Service Provider ID Qualifier	202
CA	M/I Patient First Name	310
CB	M/I Patient Last Name	311
CC	M/I Cardholder First Name	312
CD	M/I Cardholder Last Name	313
CE	M/I Home Plan	314
CF	M/I Employer Name	315
CG	M/I Employer Street Address	316
CH	M/I Employer City Address	317
CI	M/I Employer State/Province Address	318
CJ	M/I Employer Zip Postal Zone	319
CK	M/I Employer Phone Number	320
CL	M/I Employer Contact Name	321
CM	M/I Patient Street Address	322
CN	M/I Patient City Address	323
CO	M/I Patient State/Province Address	324
CP	M/I Patient Zip/Postal Zone	325
CQ	M/I Patient Phone Number	326
CR	M/I Carrier ID	327
CW	M/I Alternate ID	330
CX	M/I Patient ID Qualifier	331
CY	M/I Patient ID	332
CZ	M/I Employer ID	333
DC	M/I Dispensing Fee Submitted	412
DN	M/I Basis Of Cost Determination	423
DQ	M/I Usual And Customary Charge	426
DR	M/I Prescriber Last Name	427
DT	M/I Unit Dose Indicator	429
DU	M/I Gross Amount Due	430
DV	M/I Other Payor Amount Paid	431
DX	M/I Patient Paid Amount Submitted	433
DY	M/I Date Of Injury	434
DZ	M/I Claim/Reference ID	435
EA	M/I Originally Prescribed Product/ Service Code	445
EB	M/I Originally Prescribed Quantity	446
EC	M/I Compound Ingredient Component Count	447
ED	M/I Compound Ingredient Quantity	448
EE	M/I Compound Ingredient Drug Cost	449
EF	M/I Compound Dosage Form Description Code	450

Reject Code	Explanation	Field Number Possibly In Error
EG	M/I Compound Dispensing Unit Form Indicator	451
EH	M/I Compound Route Of Administration	452
EJ	M/I Originally Prescribed Product/ Service ID Qualifier	453
EK	M/I Scheduled Prescription ID Number	454
EM	M/I Prescription/Service Reference Number Qualifier	455
EN	M/I Associated Prescription/Service Reference Number	456
EP	M/I Associated Prescription/Service Date	457
ER	M/I Procedure Modifier Code	459
ET	M/I Quantity Prescribed	460
EU	M/I Prior Authorization Type Code	461
EV	M/I Prior Authorization Number Submitted	462
EW	M/I Intermediary Authorization Type ID	463
EX	M/I Intermediary Authorization ID	464
EY	M/I Provider ID Qualifier	465
EZ	M/I Prescriber ID Qualifier	466
E1	M/I Product/Service ID Qualifier	436
E3	M/I Incentive Amount Submitted	438
E4	M/I Reason For Service Code	439
E5	M/I Professional Service Code	440
E6	M/I Result Of Service Code	441
E7	M/I Quantity Dispensed	442
E8	M/I Other Payor Date	443
E9	M/I Provider ID	444
FO	M/I Plan ID	524
GE	M/I Percentage Sales Tax Amount Submitted	482
HA	M/I Flat Sales Tax Amount Submitted	481
HB	M/I Other Payor Amount Paid Count	341
HC	M/I Other Payor Amount Paid Qualifier	342
HD	M/I Dispensing Status	343
HE	M/I Percentage Sales Tax Rate Submitted	483
HF	M/I Quantity Intended To Be Dispensed	344
HG	M/I Days Supply Intended To Be Dispensed	345
HN	M/I Patient E-Mail Address	350

Reject Code	Explanation	Field Number Possibly In Error
H1	M/I Measurement Time	495
H2	M/I Measurement Dimension	496
H3	M/I Measurement Unit	497
H4	M/I Measurement Value	499
H5	M/I Primary Care Provider Location Code	469
H6	M/I DUR Co-Agent ID	476
H7	M/I Other Amount Claimed Submitted Count	478
H8	M/I Other Amount Claimed Submitted Qualifier	479
H9	M/I Other Amount Claimed Submitted	480
JE	M/I Percentage Sales Tax Basis Submitted	484
J9	M/I DUR Co-Agent ID Qualifier	475
KE	M/I Coupon Type	485
M1	Patient Not Covered In This Aid Category	
M2	Recipient Locked In	
M3	Host PA/MC Error	
M4	Prescription/Service Reference Number/Time Limit Exceeded	
M5	Requires Manual Claim	
M6	Host Eligibility Error	
M7	Host Drug File Error	
M8	Host Provider File Error	
ME	M/I Coupon Number	486
MZ	Error Overflow	
NE	M/I Coupon Value Amount 487	
NN	Transaction Rejected At Switch Or Intermediary	
NP	M/I Other Payor-Patient Responsibility Amount Qualifier	351
NQ	M/I Other Payor-Patient Responsibility Amount	352
NR	M/I Other Payor-Patient Responsibility Amount Count	353
NV	M/I Delay Reason Code	357
NX	M/I Submission Clarification Code Count	354
PA	PA Exhausted/Not Renewable	
PB	Invalid Transaction Count For This Transaction Code	103, 109
PC	M/I Request Claim Segment	111
PD	M/I Request Clinical Segment	111
PE	M/I Request Coordination Of Benefits/Other Payments Segment	111
PF	M/I Request Compound Segment	111

Reject Code	Explanation	Field Number Possibly In Error
PG	M/I Request Coupon Segment	111
PH	M/I Request DUR/PPS Segment	111
PJ	M/I Request Insurance Segment	111
PK	M/I Request Patient Segment	111
PM	M/I Request Pharmacy Provider Segment	111
PN	M/I Request Prescriber Segment	111
PP	M/I Request Pricing Segment	111
PR	M/I Request Prior Authorization Segment	111
PS	M/I Transaction Header Segment	111
PT	M/I Request Worker's Compensation Segment	111
PV	Non-Matched Associated Prescription/Service Date	457
PW	Non-Matched Employer ID	333
PX	Non-Matched Other Payor ID	340
PY	Non-Matched Unit Form/Route of Administration	451, 452, 600
PZ	Non-Matched Unit Of Measure To Product/Service ID	407, 600
P1	Associated Prescription/Service Reference Number Not Found	456
P2	Clinical Information Counter Out Of Sequence	493
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	447
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	337
P5	Coupon Expired	486
P6	Date Of Service Prior To Date Of Birth	304, 401
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491
P8	DUR/PPS Code Counter Out Of Sequence	473
P9	Field Is Non-Repeatable	
RA	PA Reversal Out Of Order	
RB	Multiple Partials Not Allowed	
RC	Different Drug Entity Between Partial & Completion	
RD	Mismatched Cardholder/Group IDPartial To Completion	301, 302
RE	M/I Compound Product ID Qualifier	488
RF	Improper Order Of 'Dispensing Status' Code On Partial Fill Transaction	

Reject Code	Explanation	Field Number Possibly In Error
RG	M/I Associated Prescription/service Reference Number On Completion Transaction	456
RH	M/I Associated Prescription/Service Date On Completion Transaction	457
RJ	Associated Partial Fill Transaction Not On File	
RK	Partial Fill Transaction Not Supported	
RM	Completion Transaction Not Permitted With Same 'Date Of Service' As Partial Transaction	401
RN	Plan Limits Exceeded On Intended Partial Fill Field Limitations	344, 345
RP	Out Of Sequence 'P' Reversal On Partial Fill Transaction	
RS	M/I Associated Prescription/Service Date On Partial Transaction	457
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment	
RV	Multiple Reversals Per Transmission Not Supported	109
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	478, 480
R2	Other Payor Reject Count Does Not Match Number Of Repetitions	471, 472
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	458, 459
R4	Procedure Modifier Code Invalid For Product/Service ID	407, 436,459
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06	407, 436
R6	Product/Service Not Appropriate For This Location	307, 407, 436
R7	Repeating Segment Not Allowed In Same Transaction	
R8	Syntax Error	
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	430
SE	M/I Procedure Modifier Code Count	458
SF	Other Payor Amount Paid Count Does Not Match Number Of Repetitions	341
SG	Submission Clarification Code Count Does Not Match Number of Repetitions	354
SH	Other Payor-Patient Responsibility Amount Count Does Not Match Number of Repetitions 353	
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