Prime Perspective™

QUARTERLY PHARMACY NEWSLETTER FROM PRIME THERAPEUTICS LLC

SPECIAL ISSUE NO. 25 NOVEMBER 2005

WHAT'S INSIDE

PRIME THERAPEUTICS PHARMACY PROVIDER MANUAL FOR

MEDICARE PART D

This issue of *Prime Perspective* is Prime's Pharmacy Provider Manual for Medicare Part D. Please keep this document with your Prime Pharmacy Provider Manual, distributed in September 2005.

INTRODUCTION TO MEDICARE PART D

Medicare Part D, the prescription drug benefit for Medicare beneficiaries, begins January 1, 2006. Beneficiaries may choose to retain their traditional Medicare and/or Medicare supplement plan and add a new standalone prescription drug plan (PDP), or they may enroll in a Medicare Advantage Prescription Drug (MA-PD) plan that combines medical and prescription drug coverage.

The Centers for Medicare and Medicaid Services (CMS) has contracted with private insurers (called "Part D sponsors" or "Plan sponsors") across the country to administer the Part D benefit. Prime Therapeutics (Prime) is providing pharmacy benefit management (PBM) services for a number of Part D sponsors that have contracted with CMS to offer either or both types

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CONTACT INFORMATION

PRIME WEB SITE
www.primetherapeutics.com
or www.MyRxAssistant.com

PRIME MAILING ADDRESS
Prime Therapeutics LLC
P.O. Box 64812
St. Paul, MN 55164-0812

PRIME CONTACT CENTER
800.821.4795

The Prime Contact Center has dedicated staff to assist pharmacies with processing questions or problems. Our representatives are available Monday through Friday, 7:00 a.m. to 11:00 p.m. and Saturday and Sunday, 7:30 a.m. to 6:00 p.m. (all times are Central). Representatives are also available on-call 24 hours a day, 7 days a week. Please follow the prompts after business hours.

FRAUD AND ABUSE
If you suspect fraud or abuse, please contact Prime at 800.821.4795.

PRIME CONTACT CENTER HOLIDAY HOURS

Monday, December 26, 2005, 7:00 a.m. to 6:00 p.m.

ON-CALL ASSISTANCE IS AVAILABLE
24 HOURS A DAY, 7 DAYS A WEEK

800.821.4795

Prime Perspective provides you with formulary updates, new group announcements and benefit information each quarter.

This is a special issue containing Medicare Part D information only. Formulary updates, benefit information, new group announcements and Medicare Part D plan announcements will be communicated in the December 2005 issue of *Prime Perspective*.

We value your participation in our network and hope you find *Prime Perspective* a useful source of information. If you have questions or comments, please contact the newsletter editor, Julie Damman, by email at **jdamman@primetherapeutics.com** or call **651.286.4203** or **800.858.0723, ext. 4203**.

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of Part D plans. Prime will provide prescription benefit services through two newly created networks known as the Prime Therapeutics Standard (Prime Standard) and the Prime Therapeutics Extended (Prime Extended) networks, which include Long Term Care (LTC), Home Infusion Therapy (HIT), and Indian Health Service, Indian Tribe and Tribal Organization, and Urban Indian Organization (I/T/U). In this capacity, Prime will manage the pharmacy network, maintain the formulary, process pharmacy claims, and deliver Medication Therapy Management (MTM) services to eligible beneficiaries and perform other PBM services on behalf of its Plan sponsors.

As of January 1, 2006, Prime's Plan sponsors for Medicare Part D include the following:

- Blue Cross and Blue Shield of Minnesota Secure Blue MSHO
- First Plan of Minnesota
- PrimeWest Health System
- South Country Health Alliance

Health Insurance Service Corporation (HISC)
- Blue Cross and Blue Shield of Illinois
- Blue Cross and Blue Shield of New Mexico
- Blue Cross and Blue Shield of Oklahoma
- Blue Cross and Blue Shield of Texas

Northern Plains Alliance
- Blue Cross and Blue Shield of Minnesota
- Blue Cross and Blue Shield of Montana
- Blue Cross and Blue Shield of Nebraska
- Blue Cross Blue Shield of North Dakota
- Blue Cross Blue Shield of Wyoming
- Wellmark Blue Cross and Blue Shield of Iowa
- Wellmark Blue Cross and Blue Shield of South Dakota

Employer Groups
Retirees with Employer/Union plans may be covered under Group PDP or Group MA-PD plans. These are generally expected to be full replacement plans for which the retirees' commercial coverage is terminated and the beneficiary is issued a **new insurance card with unique BIN/PCN combinations**. Please refer to the Contact Reference Guide on page 16. For processing

information, refer to the Prime Medicare Part D Payor Sheet beginning on page 26 of this communication.

Please remember to ask the beneficiary for his or her ID card

For a list of Plan sponsors that Prime represents, along with BIN/PCN combinations known as of November 14, 2005, please refer to the tables on pages 4 and 5 of this communication. **This, however, is not a final list of all the Medicare Part D BIN/PCN numbers.** As new Medicare Part D information becomes available, Prime will update its web site at **www.primetherapeutics.com**.

MEDICARE RESPONSIBILITIES OF PHARMACY

Prime's Pharmacy Participation Agreement contains specific provisions that contracted pharmacies must follow to ensure compliance with CMS regulations. Every participating Prime network pharmacy has a signed copy of the Agreement. For your convenience, we have included some relevant information from your Agreement, which addresses specific program administration details for Medicare Part D.

PRIME THERAPEUTICS PHARMACY PARTICIPATION AGREEMENT

1. **Record Retention and Right to Inspect.** Subject to the Freedom of Information Act (FOIA) or HIPAA, at no charge to Prime or Plan sponsors, Pharmacy shall retain and agrees that Prime, Plan 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 this Agreement or as each may deem necessary to enforce this 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 ten (10) years following the date of service, last date of this 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 Beneficiaries, and any additional relevant information that Prime, Plan sponsor, CMS, the Comptroller General, or their designees may require. The terms of this Section shall survive the termination of this Agreement.

   1.1 If Prime or Plan 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' determination.

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

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

2. **Confidentiality and Enrollee Record Requirements.** Pharmacy shall maintain any health or enrollment information regarding Beneficiaries in an accurate and timely manner and shall provide timely access by the Beneficiaries to the records and information that pertains to them. Pharmacy shall safeguard the privacy of the information that identifies a particular Beneficiary 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.

3. **Prompt Payment.** Prime shall pay Pharmacy for Covered Services rendered to Beneficiaries in accordance with the applicable Exhibit B, Prime

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MEDICARE PART D PROCESSING INFORMATION

Plan Sponsor	Plan Name	BIN	PCN	Contact Center	Service Area
Northern Plains Alliance BCBS of MN, BCBS of MT, BCBS of ND, BCBS of NE, BCBS of WY, Wellmark BCBS of IA, Wellmark BCBS of SD	MedicareBlue Rx	610455	PDP25	800.693.6619	CMS Medicare Part D PDP Region 25
Northern Plains Alliance Employer Groups	MedicareBlue Rx	610455	PDG25	800.693.6619	CMS Medicare part D PDP Region 25
Northern Plains Alliance BCBS of MN, BCBS of MT, BCBS of ND, BCBS of NE, BCBS of WY, Wellmark BCBS of IA, Wellmark BCBS of SD	MedicareBlue PPO	610455	MPD19	800.693.6619	CMS Medicare Part D MAPD Region 19
HCSC Insurance Service Corporation (HISC) BCBS of IL, BCBS of NM, BCBS of TX	BCBS of IL Blue Medicare Rx	011552	PDPIL	800.693.6704	PDP Region 17
	BCBS of NM Blue Medicare Rx	011552	PDPNM	800.693.7018	PDP Region 26
	BCBS of TX Blue Medicare Rx	011552	PDPTX	888.229.2812	PDP Region 22
HCSC Insurance Service Corporation (HISC) Employer Groups BCBS of IL, BCBS of NM, BCBS of TX	BCBS of IL Blue Medicare Rx	011552	PDGIL	800.693.6704	PDP Region 17
	BCBS of NM Blue Medicare Rx	011552	PDGNM	800.693.7018	PDP Region 26
	BCBS of TX Blue Medicare Rx	011552	PDGTX	888.229.2812	PDP Region 22
HISC BCBS of New Mexico	BCBS of NM Blue Medicare PPO	011552	MPDNM	800.693.7018	MA-PD Region 20, NM Counties: Bernalillo, Catron, Chaves, Cibola, Colfax, Curry, De Baca, Dona Ana, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, San Juan, San Miguel, Sandoval, Santa Fe, Sierra, Socorro, Taos, Torrance, Union, Valencia
HISC BCBS of New Mexico Employer Groups	BCBS of NM Blue Medicare PPO	011552	MPGNM	800.693.7018	MA-PD Region 20, NM Counties: Bernalillo, Catron, Chaves, Cibola, Colfax, Curry, De Baca, Dona Ana, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, San Juan, San Miguel, Sandoval, Santa Fe, Sierra, Socorro, Taos, Torrance, Union, Valencia
HISC BCBS of Texas	BCBS of TX Blue Medicare PPO	011552	MPDTX	888.229.2812	MA-PD Region 17, TX Counties: El Paso, Galveston, Harris, Jefferson, Montgomery
HISC BCBS of Texas Employer Groups	BCBS of TX Blue Medicare PPO	011552	MPGTX	888.229.2812	MA-PD Region 17, TX Counties: El Paso, Galveston, Harris, Jefferson, Montgomery
BCBS of Minnesota	Secure Blue MSHO*	610455	MPDBP	800.821.4795	MN Counties: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cottonwood, Crow Wing, Dakota, Dodge, Faribault, Filmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmstead, Otter Tail, Pennsington, Pine (partial), Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Scott, Sherburne, Sibley, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright, Yellow Medicine Continued on page 5

*MSHO (Minnesota Senior Health Options)

MEDICARE PART D PROCESSING INFORMATION continued

Plan Sponsor	Plan Name	BIN	PCN	Contact Center	Service Area
BCBS of Oklahoma	BCBS of OK Medicare Blue Rx	610455	PDPOK	888.229.2978	PDP Region 23
BCBS of Oklahoma Employer Groups	BCBS of OK Medicare Blue Rx	610455	PDGOK	888.229.2978	PDP Region 23
First Plan of Minnesota	First Plan Blue MSHO*	610455	MPDFH	800.821.4795	MN Counties: Carlton, Cook, Koochiching, Lake, St. Louis
PrimeWest Health System	PrimeWest MSHO*	610455	MPDPW	800.821.4795	MN Counties: Big Stone, Douglas, Grant, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, Traverse
South Country Health Alliance	AbilityCare	610455	MPDSA	800.821.4795	MN Counties: Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha, Waseca
South Country Health Alliance	South Country Health Alliance MSHO*	610455	MPDSM	800.821-4795	MN Counties: Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha, Waseca

*MSHO (Minnesota Senior Health Options)

Medicare Network(s) Rate and Terms Exhibit, to this Agreement. Any clean claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) 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.

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

5. **Access to Negotiated Prices.** Pharmacy shall provide Beneficiaries access to negotiated prices for all drugs on the Drug Formulary, even when Beneficiary is not entitled to any benefit under the terms of the Benefit Plan under the Medicare Programs.

6. **Hold Harmless.**

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

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

7. **Continuation of Benefits.** Notwithstanding Article 6 of the Agreement, Pharmacy shall continue to provide services to Beneficiaries for the duration of the applicable contract between CMS and the respective Plan sponsors, and with respect to Beneficiaries who are hospitalized on the date that the applicable Plan sponsor's agreement with CMS terminates or expires, or if the Plan sponsor becomes insolvent, through the date of such Beneficiary's discharge.

8. **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.

9. **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 this Agreement.

10. **Monitoring and Approval Rights.** Pharmacy acknowledges and agrees that Prime and each Plan 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 Plan sponsor shall monitor the performance of Pharmacy under this Agreement, that Pharmacy shall perform its obligations under this Agreement consistent with Plan sponsor's contract with CMS, and that each Plan sponsor retains the right at its own discretion or as directed by CMS, to approve, suspend or terminate this Agreement as it relates to that Benefit Plan.

11. **Data Collection Requirements.** Pharmacy acknowledges that Prime or Plan 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 Plan 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.

12. **Price Disclosure Obligations of Pharmacy.** Pharmacy shall inform a Beneficiary, 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 Plan sponsor of the lowest-priced, generically equivalent drug, if one exists for the Beneficiary's Benefit Plan, as well as any associated differential in price.

13. **Real-Time Adjudication.** Pharmacy shall use a real-time POS claims adjudication system, as specified by Prime.

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

15. **Delegation of Duties.** The parties hereto acknowledge that Prime oversees and is accountable to the Plan 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 Plan sponsor, such delegation shall be subject to the regulations governing participation in such Medicare Programs, including all CMS guidelines and instructions.

16. **Minimum Standards.** Pharmacy agrees to comply with the minimum performance and service criteria contained in Exhibit C of your Agreement.

Grievances

CMS requires plan sponsors and their PBMs to establish processes to promptly address grievances from beneficiaries. A grievance is any complaint or dispute, other than one involving an appeal/coverage determination, expressing dissatisfaction with any aspect of a Part D sponsor's operation, activities or behavior. In the course of investigating and addressing a grievance, Prime may need to obtain information from a pharmacy or pharmacies. We appreciate your prompt and thorough response to any request for information regarding a grievance.

Per CMS requirements and Prime's Agreement, Prime requires pharmacies to post in a public area, or hand out with each beneficiary's prescription, a copy of the *Medicare Prescription Drug Coverage and Your Rights*. For a copy of this document, please refer to page 8 of this communication or visit **www.cms.hhs.gov/regulations/pra**.

Coverage Override Requests and Appeals

Prime has designated two types of coverage override requests:

- **Clinical Coverage Requests.** This includes requests for:
  - Formulary exceptions
  - Override of a clinical program edit including, but not limited to, prior authorization, quantity limits and step therapy
- **Benefit Coverage Determination Requests.** This includes the request for coverage of a claim that has been rejected at the point of sale due to the limitations of the benefit. This includes drugs not covered by the benefit, drugs not covered under Part D and/or drugs with limited coverage (i.e., high-dollar limits, age/gender edits, certain compounds and quantity limits).

Fraud, Waste and Abuse

For suspected fraud or abuse by beneficiary, prescriber provider or pharmacy, notify Prime's Contact Center at:

Prime Therapeutics LLC
P.O. Box 64182
St. Paul, MN 55164-0812

Phone: 800.821.4795

Quality Assurance and Drug Utilization Review

CMS requires all Part D sponsors to have in place quality assurance measures and systems to reduce beneficiary medication errors and adverse drug interactions. One such requirement is the use of concurrent drug utilization review (DUR) systems, policies and/or procedures designed to ensure that a review of the prescribed drug therapy is performed before each prescription is dispensed to a beneficiary in a Part D sponsor's plan, typically at the point of sale or point of distribution. These procedures should screen for potential drug therapy problems due to therapeutic duplication, age and/or gender-related contraindications, over-utilization and under-utilization, drug-drug interactions, incorrect drug dosage or duration of drug therapy, drug-allergy contraindications or clinical abuse/misuse. In general, this regulation was designed to comply with section 4401 of the Omnibus Reconciliation Act of 1990, which CMS believes effectively outlines widely accepted standards for pharmacy practice. CMS has stated, however, that they defer to State regulations as the existing authority for regulating pharmacy practice.

While Prime's concurrent DUR edits utilized during the claim submission and adjudication process are important steps toward complying with these regulations, they are not the only appropriate measures. As a participating provider in Prime's Medicare Part D network(s), we require that you review, update and/or implement such quality assurance systems and procedures at your point(s) of sale or point(s) of distribution to ensure you comply with this CMS regulation. Please further ensure that all employees or other agents who are empowered to dispense medication are aware of and utilizing these drug utilization review systems and procedures and are following currently accepted standards for contemporary pharmacy practice as established by the applicable State.

If you wish to review the CMS regulation in its entirety, please reference section 42 C.F.R. § 423.153 of the Final Rule for the Medicare Prescription Drug Benefit, which can be found in the Federal Register Vol. 70, No. 18, published Friday, January 28, 2005.

Medicare Prescription Drug Coverage and Your Rights

You **have the right to get a written explanation** from your Medicare drug plan if:

- Your doctor or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed by your doctor.
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

You **also have the right to ask** your Medicare drug plan **for an exception** if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;" or
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a written explanation about why a prescription is not covered or to ask for an exception if you believe you need a drug that is not on your drug plan's formulary or believe you should get a drug you need at a lower cost-sharing amount.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE (1-800-633-4227) to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:
  1. The prescription drug(s) that you believe you need.
  2. The name of the pharmacy or physician who told you that the prescription drug(s) is not covered.
  3. The date you were told that the prescription drug(s) is not covered.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to distribute this information collection once it has been completed is one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form No. CMS-10147 (mm/dd/yyyy)

MEDICARE CLAIMS PROCESSING

General Processing Guidelines

The following fields are required in order for Prime to establish eligibility:

- BIN
- PCN
- Member ID
- Gender
- DOB
- DEA #

Part D sponsors may require additional fields. Please rely on POS messaging for processing information.

Dispense As Written (DAW)

The pharmacy must submit an accurate Dispense as Written (DAW) code, in accordance with NCPDP specifications. DAW submissions may change the calculation of the claims adjudication depending upon the Part D Plan sponsor's specifications. The pharmacy will be liable for any miscalculations and/or adjustments resulting from incorrect submission of a DAW code.

DAW 0 – No DAW Indicated

DAW 1 – Substitution Allowed – Dispense As Written By Prescriber

DAW 2 – Substitution Allowed – Patient Requested Product Dispensed

DAW 3 – Substitution Allowed – Pharmacist Selected Product Dispensed

DAW 4 – Substitution Allowed – No Generic Available

DAW 5 – Substitution Allowed – Brand Dispensed As Generic, Priced As Generic

DAW 7 – Substitution Not Allowed – Brand Mandated By Law

Claims Processing Window

Participating pharmacies have 90 days from the date of service to submit claims to Prime through the POS claim adjudication system.

Claim Reversals

The pharmacy must submit a claim reversal when a beneficiary fails to pick up a filled prescription within 14 calendar days. Such reversals must be submitted on-line through the POS system within 3 business days following the 14 calendar day period.

Long-Term Care (LTC) Pharmacy

The Medicare Modernization Act (MMA) provides that CMS may create standards to ensure convenient pharmacy access for Part D beneficiaries who reside in long-term care (LTC) facilities.

CMS' definition of an LTC pharmacy encompasses not only Skilled Nursing Facilities (SNFs), as defined in section 1819(a) of the Social Security Act, but also any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q)(1)(B) of the Social Security Act. This definition generally includes Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and Institutes for Mental Disease (IMDs), and inpatient psychiatric hospitals, along with skilled nursing and nursing facilities.

Those beneficiaries residing in group homes or residential housing arrangements are generally not considered institutionalized individuals and, therefore, Prescription Drug Services for residents of such facilities are considered retail Prescription Drug Services and not long-term care Prescription Drug Services.

CMS has developed the following minimum performance and service criteria for pharmacies providing LTC service, which is based on widely used best practices in the market today along with input from various CMS divisions and external stakeholders.

PRIME THERAPEUTICS MEDICARE PART D
Long Term Care Pharmacy Network
Minimum Performance Required by CMS

1. **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.

2. **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 an 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 staffs are proficient in Pharmacy's processes for ordering and receiving of 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.

3. **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.

4. **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.

5. **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 split or crushed or provided in suspensions or gel forms to facilitate effective drug delivery.

6. **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.

7. **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 in-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."

8. **Emergency Boxes.** Pharmacy must provide "emergency" supply of medications as required by the facility in compliance with State requirements.

9. **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.

10. **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.

LTC Processing Requirements

Prime requires LTC pharmacies to submit NCPDP field 307-C7 (Patient Location) with a value of "03" or "05" to properly identify the claim as initiating from an LTC pharmacy.

- **For an LTC resident use code 03 = Nursing home.** This code is broad enough to encompass all claims for patients who reside in LTC facilities.
- **For an assisted-living resident use code 05 = Rest home.** This code is broad enough to encompass all claims for patients who reside in rest homes.

Home Infusion Therapy (HIT) Pharmacy

A Home Infusion Therapy (HIT) pharmacy is a participating network pharmacy specializing in supplying beneficiaries with HIT medications and supplies.

HIT Processing Requirements

For those HIT pharmacies utilizing electronic claims submission, please note that **Prime requires HIT pharmacies to submit NCPDP field 307-C7 (Patient Location) with a value of "01" to properly identify the claim was initiated from an HIT pharmacy**.

Prime strongly encourages the use of NCPDP 5.1 standards, or most current industry-utilized version, for electronic claims submission by all participating pharmacies. For those HIT pharmacies that do not have the ability to submit NCPDP-compliant electronic claims, paper claims can be substituted with prior written approval from Prime. Please contact Prime for more information if you believe you will not be able to comply with NCPDP standards.

Indian Health Service, Indian Tribe and Tribal Organization, and Urban Indian Organization (I/T/U) Pharmacy

I/T/U Processing Requirements

There are no special processing requirements for I/T/U claims beyond those for standard retail claims.

Prime strongly encourages the use of NCPDP 5.1 standards, or most current industry-utilized version, for electronic claims submission by all participating pharmacies. Those I/T/U pharmacies that do not have the ability to submit NCPDP-compliant electronic claims may submit claims by calling a toll-free number for non-electronic claims and sending a paper claim as confirmation.

Out-of-Network Pharmacy

An out-of-network pharmacy is one that is not under contract with Prime to service our Part D sponsors' beneficiaries. In limited cases, Medicare Part D beneficiaries can use out-of-network pharmacies, but they may experience additional costs and/or coverage limitations based on the sponsoring Plan design.

Paper Claims

Prime requires participating pharmacies to submit claims electronically in NCPDP 5.1 standard format, or most current industry-utilized version, for adjudication on-line at the beneficiary's point of service. There are limited situations where a paper claim submission from a pharmacy, with advance written authorization, is appropriate — the primary cases being those for specific HIT and I/T/U pharmacies as noted above.

The pharmacy will assume all risks including, but not limited to, eligibility, drug coverage copayment, etc. when submitting a paper claim.

Medicare Part D Universal Claim Forms can be sent to:

Prime Therapeutics LLC
P.O. Box 64813
St. Paul, MN 55164-0813

MEDICARE BENEFIT PLANS

Standard Benefit

CMS established a Medicare Part D benefit "defined standard" to serve as a minimum benefit guarantee and allow for comparisons across plans offered by various Part D Plan sponsors. The standard benefit structure for the year 2006 includes:

- A deductible of $250
- Coinsurance of 25 percent up to an initial coverage limit of $2,250
- Protection against high out-of-pocket prescription drug costs, with copays of $2 for generics and preferred drugs that are multiple-source drugs and $5 for all other drugs or coinsurance of 5 percent of the price once a beneficiary's true out-of-pocket spending reaches a limit of $3,600

Alternative Benefits

While Part D plan sponsors may offer alternatives to the standard benefit design, any variant must meet certain actuarial tests to gain approval from CMS prior to offering. In general, these tests are intended to assure that the plan provides the same or greater value than the "defined standard." These variants fall into three main categories:

- "Actuarially equivalent" coverages can modify the cost-sharing structure to be different than, but actuarially equivalent to, the defined standard. For example, an actuarially equivalent design might have tiered copayments of a low dollar amount for a generic drug and higher amounts for preferred brand-name drugs and for non-preferred brand-name drugs. All other elements of the benefit design such as deductible and the initial coverage limit would be the same as for the standard Part D benefit.
- "Basic alternative" coverages can modify any coverage element, including the deductible, initial coverage limit or cost-sharing structure, but only in a manner where the entire coverage package has the same actuarial value as defined standard coverage.
- "Enhanced alternative" coverages are those where the standard benefit design elements are modified to create "richer" coverage with an actuarial value that is greater than defined standard coverage.

Plan Web Sites

The following information can be found on Part D sponsor web sites. For detailed information on these specific topics, please visit the individual web sites for the Part D sponsors associated with Prime. See Contact Reference Guides on pages 14 – 16 for web site addresses.

- Part D Plan's toll-free customer service number, TTY/TDD number, physical or Post Office Box address and hours of operation
- Part D Plan description:
  - Service area
  - Benefits
    - Applicable conditions and limitations
    - Premiums
    - Cost sharing (e.g., copayments, coinsurance and deductibles), including a description of how an individual may obtain additional information on the plan's tiered or copayment level applicable to each drug
    - Any conditions associated with receipt or use of benefits
    - 60-day notice regarding removal or change in the preferred or tiered cost-sharing status of a Part D drug. This information is to be maintained on the web site until the next annual mailing of the updated formulary
  - Pharmacy access information
    - Pharmacy addresses and type of pharmacy (e.g., retail, mail-order, home infusion)
    - Number of pharmacies in network
    - How the Plan meets access requirements (e.g., <Plan sponsor> has contracts with pharmacies that equal or exceed CMS requirements for pharmacy access in your area)
  - Out-of-network coverage
  - Current formulary information (updated monthly)

  - Grievances, coverage determinations, appeals procedures and exceptions process
  - Quality assurance policies and procedures, including Medication Therapy Management and/or drug utilization management
  - Potential for contract termination
  - Beneficiaries' and plan's rights and responsibilities upon disenrollment
  - How to obtain an aggregate number of the Plan's grievances, appeals and exceptions
- Enrollment instructions and forms
- Evidence of coverage
- Privacy notice
- Summary of benefits

In addition to the CMS-required information, the following subjects can also be found on the Part D sponsors' web sites:

- Copayments/coinsurance/deductibles
- Formulary exceptions process
- Formulary listings
- General retail supply limitations
- General exclusions
- Medicare Part D Utilization Management programs, which have been approved by CMS prior to use, including the following:
  - **Step Therapy** – Step therapy requires previous use of one or more drugs before the coverage of a different drug is provided. Please refer to the plan formulary to determine if a drug is subject to step therapy.
  - **Quantity Limitations** – Quantity limits are applied to certain drugs based on the approved dosing limits established during the FDA approval process. Quantity limits are applied to the number of days supply or units dispensed for each prescription. Please refer to the health plan formulary to determine if a drug is subject to quantity limits.
  - **Prior Authorizations** – Prior authorizations may be required for certain drugs as determined by the plan formulary. Please refer to the health plan formulary to determine if a drug requires prior authorization.

Drugs Excluded Under Medicare Part D

Not all drugs will be available under Medicare Part D basic coverage. The cost of drugs excluded from Medicare prescription drug basic coverage is the responsibility of the beneficiary. Exclusions include:

- Drugs, or uses of drugs, and vaccines for which coverage is available under Part A or Part B
- Drugs excluded from Medicare drug discount card coverage
- Compounds containing non-approved FDA medications or CMS-excluded drug categories

In addition, Part D Plan sponsors cannot include any of the nine excluded therapeutic categories listed below:

- Anorexia, weight loss or weight gain drugs
- Barbiturates
- Benzodiazepines
- Drugs used for cosmetic reasons or hair growth
- Drugs used for the relief of coughs and colds
- Infertility drugs (and infertility injectables)
- Non-prescription drugs/OTCs (except insulin)
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
- Prescription vitamins and minerals, except prenatal vitamins and fluoride preparations

Plan Contact Reference Guides

The tables on pages 14 – 16 contain contact information for all plans administered by Prime. For your convenience, the tables are organized by PDP, MA-PD and Employer Groups.

PDP CONTACT REFERENCE GUIDE

PDP Product Offering

PDPs are Prescription Drug Plans (such as private insurance companies and PBMs) that will offer a fully insured drug benefit

PDP

Region	Region 25	Region 17	Region 26	Region 22	Region 23
State(s)	IA, MN, MT, NE, ND, SD, WY	Illinois	New Mexico	Texas	Oklahoma
Name	RAS/Northern Plains Alliance	HISC			Oklahoma
Product Name	MedicareBlue Rx	Blue MedicareRx			Medicare Blue Rx
Web Site	www.YourMedicareSolutions.com	www.bcbsil.com	www.bcbsnm.com	www.bcbstx.com	www.bcbsok.com
Pre-Enrollment	866.456.3725 Monday – Friday: 8 a.m. to 6 p.m. CT	888.285.2249 Monday – Friday: 7 a.m. to 7 p.m. CT	888.285.2254 Monday – Friday: 6 a.m. to 6 p.m. MT	888.579.9373 Monday – Friday: 7 a.m. to 7 p.m. CT	888.844.3781 24 hours a day/ 7 days a week
Beneficiary Services (Post-Enrollment)	888.832.0075 Monday – Friday: 7 a.m. to 7 p.m. CT	888.285.2249 Monday – Friday: 7 a.m. to 7 p.m. CT	888.285.2254 Monday – Friday: 6 a.m. to 6 p.m. MT	888.579.9373 Monday – Friday: 7 a.m. to 7 p.m. CT	888.844.3781 Monday – Friday: 7 a.m. to 7 p.m. CT
Pharmacy Contact Center	800.693.6619 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT	800.693.6704 Monday – Friday 7 a.m. to11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT	888.693.7018 Monday – Friday 6 a.m. to 10 p.m. MT Saturday – Sunday: 6:30 a.m. to 7 p.m. MT	888.229.2812 Monday – Friday 7 a.m. to 11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT	888.229.2978 Monday – Friday 7 a.m. to 11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT

MA-PD Product Offering

MA-PD

Medicare Advantage Plans were originally known as Medicare+Choice; they now offer a prescription drug benefit and are referred to as MA-PDs (Medicare Advantage with a Prescription Drug Plan)

Region	Region 19	Region 20	Region 17	Minnesota Only			
State(s)	IA, MN, MT, NE, ND, SD, WY	New Mexico	Texas	Minnesota	Minnesota	Minnesota	Minnesota
Name	RAS/Northern Plains Alliance	HISC	HISC	PrimeWest Health System	First Plan of Minnesota	South Country Health Alliance	MN-MSHO
Product Name	MedicareBlue PPO	Blue Medicare PPO	Blue Medicare PPO	PrimeWest Senior Health Complete	First Plan Blue MSHO	SeniorCare Complete and AbilityCare (SNP)	SecureBlue
Web Site	www.YourMedicareSolutions.com	www.bcbsnm.com	www.bcbstx.com	www.primewest.org	www.firstplan.org	www.mnscha.org	www.bluecrossmn.com
Pre-Enrollment	866.456.7731 Monday – Friday: 8 a.m. to 6 p.m. CT	800.718.2031	800.718.2031	800.366.2906	800.635.4159 218.724.3083	MN-MSHO 866.477.1601	MN-MSHO 866.477.1601
Beneficiary Services (Post-Enrollment)	888.457.3009 Monday – Friday: 8 a.m. to 6 p.m. CT	888.277.5507 Monday – Friday: 6 a.m. to 6 p.m. MT	888.277.5507 Monday – Friday: 7 a.m. to 7 p.m. CT	800.366.2906	800.635.4159 218.724.3083	MN-MSHO 866.477.1601	MN-MSHO 866.477.1601
Pharmacy Contact Center	800.693.6619 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday & Sunday: 7:30 a.m. to 8 p.m. CT	800.693.7018 Monday – Friday: 6 a.m. to 10 p.m. MT Saturday & Sunday: 6:30 a.m. to 7 p.m. MT	888.229.2812 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday & Sunday: 7:30 a.m. to 8 p.m. CT	800.821.4795 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday & Sunday: 7:30 a.m. to 8 p.m. CT	800.821.4795 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday & Sunday: 7:30 a.m. to 8 p.m. CT	800.821.4795 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday & Sunday: 7:30 a.m. to 8 p.m. CT	800.821.4795 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday & Sunday: 7:30 a.m. to 8 p.m. CT

EMPLOYER GROUPS CONTACT REFERENCE GUIDE

PRIME Therapeutics®	Product Offering — Employer Groups				Employer Groups
Region	**Region 25**	**Region 17**	**Region 26**	**Region 22**	**Region 23**
State(s)	IA, MN, MT, NE, ND, SD, WY	Illinois	New Mexico	Texas	Oklahoma
Name	Northern Plains Alliance	Blue Cross and Blue Shield (HISC)			Blue Cross and Blue Shield Oklahoma
Product Name	MedicareBlue Rx	Blue MedicareRx			Medicare Blue Rx
Web Site	www.YourMedicareSolutions.com	www.bcbsil.com	www.bcbsnm.com	www.bcbstx.com	www.bcbsok.com
Beneficiary Services	877.838.3827 TTY: 800.693.3816 FAX: 888.285.2242 Monday – Friday: 7 a.m. to 7 p.m. CT	877.838.3833 TTY: 800.693.3816 FAX: 888.285.2242 Monday – Friday: 7 a.m. to 7 p.m. CT	877.838.3875 TTY: 800.693.3816 FAX: 888.285.2242 Monday – Friday: 6 a.m. to 6 p.m. MT	877.838.3871 TTY: 800.693.3816 FAX: 888.285.2242 Monday – Friday: 7 a.m. to 7 p.m. CT	877.838.3877 TTY: 800.693.3816 FAX: 888.285.2242 Monday – Friday: 7 a.m. to 7 p.m. CT
Pharmacy Contact Center	800.693.6619 Monday – Friday: 7 a.m. to 11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT	800.693.6704 Monday – Friday 7 a.m. to11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT	888.693.7018 Monday – Friday 6 a.m. to 10 p.m. MT Saturday – Sunday: 6:30 a.m. to 7 p.m. MT	888.229.2812 Monday – Friday 7 a.m. to 11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT	888.229.2978 Monday – Friday 7 a.m. to 11 p.m. CT Saturday – Sunday: 7:30 a.m. to 8 p.m. CT

MEDICARE PART B DRUGS

Medicare drug coverage is a complex issue; not only must pharmacists understand the Medicare Part D (prescription drug) benefit, but also recognize that many drugs may be covered under either Part D or Part B (medical insurance), depending on the circumstances. For example, immunosuppressant drugs are covered under Part B for a finite period of time for beneficiaries who have had a Medicare-covered transplant; otherwise they are covered under Part D. The table below lists examples of circumstances for Part B vs Part D coverage.

In order to ease the process for both the pharmacist and the beneficiary, we are making every effort to allow claims to adjudicate appropriately the first time. In some instances, this will include utilizing previously obtained diagnosis information or looking at concurrent use of other medications to help make coverage determinations. There may be some cases when a claim is appropriate for Part D, but will reject because the drug usually should be covered by Part B; the reject will include a message directing coverage to Part B. In these cases, overrides will be available, with appropriate indication or circumstances for Part D, through our Contact Center.

Medicare prescription drug coverage is a complex issue for pharmacists as well as beneficiaries; we are working diligently to make it as simple as possible. Procedures may vary for an MA-PD vs a PDP. Watch for further details in the near future.

COORDINATION OF BENEFITS

Coordination of Benefits (COB)

Beginning January 1, 2006, Medicare Part D COB claims can be processed on Prime's claims processing system. For processing requirements, please refer to the Payor Sheets on pages 26 – 43 of this communication.

When a Medicare Part D beneficiary visits a pharmacy to fill a prescription, the pharmacist can process the primary claim via direct connect, if applicable, or switch to the primary PDP. Once the claim adjudicates, a response message will be generated back to the pharmacy that contains the claim transaction information as well as supplemental coverage that the beneficiary has. This response message can generally accommodate multiple supplemental coverages and includes all information required to process the supplemental claim(s). Supplemental claims must be processed through a switch in order to correctly capture these transactions for True Out-of-Pocket (TrOOP) calculation purposes. This process is designed to function real-time and to process all levels of payor submissions for a claim at the point of sale. When the primary payor or payor order information is not known or is in doubt, the pharmacist will have the ability to send an E1 Eligibility Query to the TrOOP facilitator to determine proper payor order.

Additional information on COB can be found at **www.cms.hhs.gov/medicare/cob**.

Part B vs Part D Coverage Examples

Drug Product	Part B Coverage	**Part D Coverage** (Drugs used outside of a clinic setting only)
Oral anti-emetic drugs (e.g., Zofran)	Within 48 hours post chemotherapy	After 48 hours post chemotherapy
Immunosuppressants (e.g., CellCept, Neoral, Myfortic)	Three years coverage post Medicare-covered transplant	Not related to Medicare-covered transplant, and post transplant after Part B coverage is concluded
Vaccine, Hepatitis B	Intermediate- and high-risk patients	Administered outside of a physician's office to low-risk patients
IVIG (e.g., Gammagard)	For indication of primary immune deficiency	Other indications
Diabetic test meter/strips; nebulizer devices/medications; antihemophiliac products; influenza and pneumococcal vaccines	Covered under Part B only	No coverage
Recombinant Human Erythropoietin (e.g., Epogen, Aranesp)	ESRD patients on dialysis	Other conditions, not administered in a physician's office

True Out of Pocket (TrOOP)

TrOOP costs refer to those qualifying out-of-pocket expenses that a Medicare beneficiary pays for Part D covered drugs.

As drug spend accumulates, the beneficiary moves through the different initial phases of plan coverage. In the standard benefit design, a beneficiary must first satisfy a $250 deductible before he or she moves to the initial coverage phase of 25 percent beneficiary coinsurance. After the beneficiary satisfies a total of $2,500 drug spend, he or she reaches the coverage gap. The beneficiary remains in the coverage gap until he or she satisfies $3,600 of TrOOP expenses, and moves to the catastrophic coverage phase. All qualifying payments made in each phase of the plan design count toward TrOOP accumulation. The beneficiary's plan premium does not count toward TrOOP accumulation. Ultimately, the TrOOP accumulation determines when the beneficiary reaches the $3,600 catastrophic coverage threshold. Payments qualify for TrOOP accumulation if the payment is for covered Part D drugs (including those covered through a coverage determination or appeal) and are made by the beneficiary, another person on behalf of the beneficiary, CMS as part of the low-income subsidy program, a State Pharmaceutical Assistance Program (SPAP) or a registered charity.

Payments do not count toward TrOOP accumulation if they are made by a group health plan, insurance, or another third-party payment arrangement. Some examples of entities whose wraparound coverage does not count toward TrOOP are: MA plans, Medicaid, VA or TRICARE programs, Indian Health Services, and many others.

CMS has contracted with NDC Health to act as the TrOOP facilitator. NDC Health will be responsible for receiving and maintaining Part D eligibility data, providing responses to pharmacy eligibility queries (E1 transactions), receiving and routing secondary paid claims data to the Part D plan (both real-time and batch), providing CMS copies of the secondary claims transactions, and maintaining a Help Desk.

For additional information on TrOOP transactions, visit **http://medifacd.ndchealth.com**.

E1 Eligibility Query

The E1 Eligibility Query is a transaction utilized by CMS to assist pharmacies in determining payor order for a given beneficiary when this information is not known. Even after the Medicare Part D program is operational, beneficiaries may not know their Medicare ID numbers or their coverage payment order. This transaction is specifically designed to assist pharmacists in these types of situations. **Please note that these queries are to be submitted to the TrOOP Facilitator, NDC Health, and not to Prime or the Part D sponsors.**

The basic transaction steps are as follows:

1. Pharmacy submits the E1 transaction to the TrOOP Facilitator.
2. Facilitator uses the E1 Request to match the data contained within the Request to its Eligibility File. The Eligibility File is provided to the Facilitator by CMS and is updated nightly.
3. Facilitator returns the Response to the Pharmacy.
4. Pharmacy uses the information contained in the Response message to create the billing claim for the beneficiary.

This service is available only as a real-time transaction, not as a batch.

When submitting an E1 transaction, the pharmacy should provide the following beneficiary information:

- Date of birth
- First name
- Last name
- ZIP code
- Cardholder ID

The Facilitator will return either the information contained within its Eligibility File or it will return a rejection notice. E1 transactions can reject for one of two reasons:

- Facilitator cannot find a match or
- Facilitator finds multiple matches

In the event that a request is rejected, a reject response will be returned to the pharmacy. If the pharmacy receives a reject response, one of three conditions can apply:

- Information supplied by the pharmacy was inaccurate
- Information was incomplete
- Beneficiary is not included in the Eligibility File

The pharmacy can resubmit the E1 request with updated or more complete information, if applicable, to improve the chances for a match. Successfully matched beneficiary information returns a Response Message with the beneficiary's coverage information. The response messages are returned in the following format:

PRIMARY;BN:123456:PN:1234567890;GP:123456789012345; ID:12345678901234567890;PC:001;PH:8001234567;&ADD INS:1;BN:123456;PN:1234567890;GP:123456789012345; IC:12345678901234567890;PC:001;PH:8001234567

Additional information on E1 Transactions can be found at **http://medifacd.ndchealth.com/Pharmacies/MediFacD_Pharmacies.htm**.

Coverage Supplemental to Medicare Part D

The COB design for Medicare Part D incorporates the functions of the TrOOP Facilitator. Of the TrOOP Facilitator's multiple responsiblities, one of its most important priorities is routing supplemental claim transaction information to the primary PDP for beneficiary TrOOP balance adjustment.

The COB design relies solely on the BIN/PCN combination to identify those claims for payors that are supplemental to Part D. Specifically, beneficiaries who elect to keep their current commercial coverage concurrent with enrollment in Medicare Part D must be assigned a new, unique BIN/PCN combination in order to ensure that their supplemental transaction information is routed to the TrOOP Facilitator and on to the primary PDP.

Unique processing information will be available in the December issue of *Prime Perspective*.

Beneficiaries who elect both coverages will be issued a new insurance card with the new, unique BIN/PCN combination. This means that beginning January 1, 2006, pharmacists may experience some claim rejects if an old insurance card is presented with an expired BIN/PCN. In these cases, the pharmacist can send an "E1" eligibility query transaction to the TrOOP Facilitator. The TrOOP Facilitator will respond with the most up-to-date coverage information, including current BIN/PCN and other data requirements necessary to process the member's claim. The E1 transactions occur real time.

Please remember to ask the beneficiary for his or her ID card

TRANSITION PERIOD

To address the needs of individuals who are stabilized on certain drug regimens and to assist in the education of beneficiaries on what drugs are covered by their Part D Plan, CMS has required that Part D sponsors establish an appropriate transition process for new Part D beneficiaries whose current drug therapies may not be included in their new Part D plan's formulary.

Prime has developed claims processing functionality to handle a 30-day transitional period for retail beneficiaries and a 90-day transitional period for Long Term Care beneficiaries. This transitional period is measured from the beginning of the beneficiary's eligibility with the Part D plan. When a beneficiary currently in their transition period (i.e., within 30 days of their eligibility) presents a prescription at a network pharmacy for a drug that is not on the Part D plan's formulary but is not specifically excluded from coverage by CMS, the claim will return an informational message to the pharmacy explaining that this drug will not be covered after the transition period.

As one of the primary goals of the transition period is to alert beneficiaries of non-formulary circumstances, Prime requests that pharmacists receiving this message pass the information on to the beneficiary and suggest that the beneficiary contact their physician to explore transitioning to a formulary drug.

An example of a potential message is included here for your information – the verbiage may change slightly prior to implementation:

This drug will reject post transition grace period. Alert member to contact MD.

In most transition situations, Step Therapy, Prior Authorization or other similar Utilization Management edits will not be imposed. However, Quantity Limits will be enforced. In cases where a drug would normally be subject to Step Therapy or Prior Authorization edits, you may also receive informational POS messages like the examples below:

This drug subject to step-therapy post transition grace period.

This drug requires PA post transition grace period, contact MD.

For more information on CMS' Transition Period mandate, please visit **www.cms.hhs.gov/pdps/transition_process.pdf**.

MEDICATION THERAPY MANAGEMENT

In order to provide the highest level of service to Medicare beneficiaries, Prime will offer a Medication Therapy Management Program (MTMP) to qualifying Medicare Part D beneficiaries with the goal of optimizing therapeutic outcomes for those beneficiaries enrolled in the program.

One component of the MTMP will utilize the expertise of our network pharmacy providers to reduce the risk of potential adverse experiences and at the same time enhance beneficiary understanding through educational counseling. In exchange for this enhanced service to our Medicare Part D beneficiaries, pharmacies will be compensated for each qualified pharmacist intervention. The level of compensation will depend on the extent of intervention required to resolve the issue.

Watch for further information in early 2006, including an MTMP Exhibit to the Prime Therapeutics Pharmacy Participation Agreement for those pharmacies that are participating providers in the Prime Standard Network for Medicare. The update will provide specific details about how you can participate in the program to help improve the pharmaceutical services for qualifying beneficiaries.

REMITTANCE ADVICE

Pay Cycle Information

Prime will seek agreement from the Part D sponsors (payors) to process pharmacy payments at least twice monthly. For Part D sponsors who do not agree to this processing timeline/claims payment schedule, pharmacy payments will be processed at least once a month. For claims that are eligible for payment under the terms of the Prime Therapeutics Pharmacy Participation Agreement, the average time of payment to the pharmacy will not exceed 30 days from the processing date.

Paper Remittance Advice

For Medicare Part D, there will be a separate (from standard commercial carriers) envelope including the check and remittance advice, if applicable.

Electronic Remittance Advice

The additional payors for Medicare Part D will be included on your existing CD-ROM for payment and billing in the 835 electronic fomat, if applicable.
A COB segment will be added to the 835 format along with additional payors effective January 1, 2006.
A letter explaining these changes will be included with your CD in December.

TESTING SCENARIOS

Medicare Part D testing scenarios will be available via our web site in early to mid-December 2005. Please visit **www.primetherapeutics.com** for more details as they become available.

FAQ FOR MEDICARE PROGRAMS

What should I do if I suspect fraud or abuse by a beneficiary or provider?

Please report suspected fraud or abuse to Prime at 800.821.4795.

What will the Medicare Part D beneficiary ID cards look like?

To view the most up-to-date plan announcements, which include sample ID cards, please visit **www.primetherapeutics.com**.

What is the pay cycle and remittance changes for Medicare Part D?

Refer to page 20 of this communication for details.

How do I process a COB claim for Medicare Part D?

Prime supports the NCPDP 5.1 COB segment for Medicare Part D. For more information, refer to the Medicare Part D Supplemental Payor Sheet beginning on page 35 of this communication. Please visit **www.primetherapeutics.com** for updates to the Payor Sheets.

How many claims can I submit per transaction for Medicare Part D?

Only one occurrence is permitted for Medicare Part D.

Is the NCPDP 5.1 compound segment supported for Medicare Part D?

The compound segment is not supported at this time.

How are claims for compounded drugs processed?

Per CMS regulations, compounded claims can consist only of NDCs for FDA-approved prescription drug products. Traditional compounding powders are typically not FDA-approved drug products. To process a claim on-line for a compound prescription, the pharmacy should submit the NDC of the most expensive FDA-approved drug. Prime does not allow for multiple NDC submissions at this time. Additionally, compounded prescriptions made from CMS-excluded drug categories such as cough and cold, benzodiazipines, etc. are not covered.

What is the processing window for electronic claims?

Prime allows 90 days from the date of fill to process claims on-line.

How do I process a claim for a Medicare beneficiary in a Long Term Care facility?

For details, see page 11 of this communication, or refer to the Medicare Part D Payor Sheets beginning on page 26. Payor Sheets can also be viewed on-line at **www.primetherapeutics.com/pharmacies/payorsheet**.

How can I obtain copies of the Medicare Part D Payor Sheets?

Copies of the Medicare Part D Payor Sheets have been included in this communication, beginning on pages 26 and 35. Payor Sheets can also be viewed on-line at **www.primetherapeutics.com/pharmacies/payorsheet**.

How will I know if a beneficiary has supplemental coverage to Medicare Part D?

The pharmacist will receive POS messaging indicating processing information for any coverage supplemental to Medicare Part D.

How will I know if a beneficiary has coverage primary to Medicare Part D?

The claim will reject with POS messaging that the claim must first be submitted to primary coverage. This message may or may not include details regarding the primary payor. In cases where the primary payor information is not known, the pharmacy can submit an E1 transaction to obtain primary payor processing information. Additional information on E1 transactions can be found at **http://medifacd.ndchealth.com/Pharmacies/MediFacD_Pharmacies.htm**.

Will Prime implement a Medication Therapy Management Program (MTMP)?

Prime will implement an MTMP in early 2006. Watch for further information including an MTMP Exhibit to the Prime Therapeutics Pharmacy Participation Agreement for those pharmacies that are participating providers in the Prime Standard Network for Medicare. The update will provide specific details about how you can participate in the program to help improve the pharmaceutical services for qualifying beneficiaries.

How do I help beneficiaries obtain benefit information?

For more information on Medicare Part D benefit designs, please refer to the Plan sponsor web site. See Contact Reference Guides on pages 14 – 16.

Is Prime an approved CMS Medicare Part D sponsor?

No. Our clients are approved CMS Medicare Part D sponsors. Prime administers the benefits on behalf of our Medicare Part D sponsors.

What is the enrollment process?

Enrollment instructions and forms are available on the Plan sponsor's web site. Refer to the Contact Reference Guides on pages 14 – 16.

Where can I call for help processing a claim?

Pharmacy Contact Center phone numbers vary by region, please refer to the Contact Reference Guides on pages 14 – 16 for the appropriate phone number.

If you would like additional information, please contact Prime at:

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

Prime web site: **www.primetherapeutics.com**

Prime Contact Center: **800.821.4795**

The Prime Contact Center has dedicated staff to assist pharmacies with processing questions or problems. Our representatives are available Monday through Friday from 7:00 a.m. to 11:00 p.m., and Saturday and Sunday from 7:30 a.m. to 6:00 p.m. (all times are Central). Representatives are available on-call 24 hours a day, 7 days a week for emergency situations. Please follow the prompts after business hours.

What is the transition process and how will Prime support the transition period?

To address the needs of individuals who are stabilized on certain drug regimens and to assist in the education of beneficiaries concerning which drugs are covered by their Part D Plan, CMS has required that Part D plans establish an appropriate transition process for new Part D beneficiaries whose current drug therapies may not be included in their new Part D plan's formulary.

Prime has developed claim processing functionality to handle a 30-day transition period for retail beneficiaries and a 90-day transition period for Long Term Care beneficiaries.

What are the differences in processing for commercial plans vs Medicare Part D?

The primary difference between commercial and Medicare Part D processing is the inclusion of on-line COB with Medicare Part D. More specific details on processing differences and the values required are covered in the Payor Sheets beginnining on page 26.

Are there any impacts to commercial plans due to the Medicare Part D program?

A current commercial beneficiary who is eligible for, and elects to carry, Medicare Part D coverage, but also elects to continue with their established commercial prescription drug coverage, which is deemed to be supplemental to their new Part D coverage, **will be assigned a new, unique BIN/PCN and a new ID card from their commercial sponsor**. Unique processing information will be provided in the December issue of *Prime Perspective*. If you receive a reject code 52 "non-matched card holder", the reject may be due to a change in eligibility in the beneficiary's commercial plan.

Where can I obtain processing specifications for Medicare Part D claims adjudication?

The Payor Sheets on pages 26 – 43 of this communication are your best source for processing requirements.

Will all medications previously covered by Medicaid be covered by Medicare for dual eligibles?

Not all drug categories covered by Medicaid will be covered by Medicare for dual eligibles. Claims for items covered by Medicaid, but on the Medicare Part D list of excluded therapeutic categories, can be submitted to the beneficiary's Medicaid processor.

Where can I obtain a formulary list?

Once approved by CMS, formulary information can be found at **www.MyRxAssistant.com**.

Will testing be available?

Yes. Testing scenarios will be available via Prime's web site in early to mid-December 2005. Please visit **www.primetherapeutics.com** for more details as they become available.

When will Prime's Medicare Part D adjudication be in production?

Prime's Part D functionality will be in production as of January 1, 2006, 12:00 a.m. (midnight) Central Time.

How is Prime handling coverage of Part B vs Part D drugs?

A Part B vs Part D coverage overview is included on page 17 of this communication. We are working diligently to make it as simple as possible. Watch for further details in the near future.

What is TrOOP?

True Out-Of-Pocket (TrOOP) costs refer to those qualifying out-of-pocket expenses that a Medicare beneficiary pays for Part D covered drugs. For more details, refer to page 18 of this communication.

Under what circumstances can I submit a paper claim?

Prime requires participating pharmacies to submit claims electronically in NCPDP 5.1 standard format for adjudication on-line at the beneficiary's point of service. There are limited situations where a paper claim submission from a pharmacy, with advance written authorization, is appropriate — the primary cases being those for specific HIT and I/T/U pharmacies as noted on page 11 of this communication.

How long do I need to retain records for Medicare Part D?

Ten years per CMS requirements. CMS expects pharmacies to maintain prescription records in their original format for the greater of three years or the period required by state law, and permits the records to be transferred to an electronic format that replicates the original prescription, such as a digitized image, for the remaining years of the 10-year Part D retention period. This requirement for retention in original format applies only to prescription records; all other records that must be retained for Medicare under Parts C and D should be retained in the form(s) required by either State law or the HIPAA Privacy Rule, if applicable, or at the plan's discretion.

What is a regional plan?

For Medicare Part D, regional plans are allowed to solicit beneficiaries only in their approved geographical area.

Does Prime have national plans?

As of January 1, 2006, all of the plans associated with Prime are regional.

How will Prime process as a secondary payor in cases where the primary payor rejected the claim?

As long as the claim was submitted to, and adjudicated by, the primary payor, the outcome of that adjudication will not directly affect how Prime processes as the secondary payor. The claim will process based on the beneficiary's Medicare Part D or commerical benefit design.

As a secondary payor, will your Medicare Part D plans always pay the remainder?

No. Payment or non-payment will be subject to the beneficiary's Medicare Part D benefit design.

What are the "refill too soon" and "lost medication" policies?

Refill too soon and lost medication policies may vary by Plan sponsor. Please refer to the Plan sponsor web site for more information. See Contact Reference Guides on pages 14 – 16 of this communication, or call the Prime Contact Center.

Are vacation overrides allowed?

Vacation overrides may vary by Plan sponsor. Please refer to the Plan sponsor web site for more information. See Contact Reference Guides on pages 14 – 16.

Do your plans offer mail order? What about extended supply?

A mail order benefit is an option that many of our plans have implemented. For those plans that do have Mail Order, Retail Extended Supply Networks are available. If you are unable to process an extended supply and would like to join the Extended Supply Networks, please call the Prime Contact Center at 800.821.4795.

ADDITIONAL PART D PHARMACY INFORMATION

Prime Therapeutics Web Site

Prime will update its web site with additional Medicare Part D information as it becomes available. Please visit **www.primetherapeutics.com** to obtain updated or new information regarding the subjects in this communication, **including any additional BIN/PCN combinations and testing scenarios**.

Contact Center

If you have specific Part D questions for which you need immediate answers, please refer to the Contact Reference Guides on pages 14 – 16 of this communication for dedicated Medicare Part D Contact Center phone numbers and availability.

For other non-Medicare Part D inquiries, the Prime Contact Center has dedicated staff to assist pharmacies with processing questions or problems. Our representatives are available at **800.821.4795,** Monday through Friday from 7:00 a.m. to 11:00 p.m., Saturday and Sunday from 7:30 a.m. to 6:00 p.m. (all times are Central). Representatives are available on-call 24 hours a day, 7 days a week for emergency situations. Please follow the prompts if calling after business hours.

MyRxAssitant.com

Prime, in conjunction with our Part D sponsors, has developed a web site to serve beneficiaries with questions specific to Part D. Visitors can use the **www.MyRxAssistant.com** site to find:

- Current formulary information (updated monthly)
- Grievances, coverage determinations, appeals procedures, exceptions process management and/or drug utilization management
- Pharmacy addresses and types (e.g., retail, mail-order, home infusion, long-term care)
- Quality assurance policies and procedures, including medication therapy management and/or drug utilization management

MEDICARE PART D CHAIN SOFTWARE SET-UP

To enable Prime's Contact Center to assist your pharmacies with claims adjudication, please email your unique processing codes created to support Medicare Part D claims adjudication (i.e., BIN/PCN/ CONDOR CODES/INPUT CODES) to **pharmacy@primetherapeutics.com**.

PLAN ANNOUNCEMENTS

Medicare Part D Plan Announcements, which contain sample member ID cards, will be placed on Prime's web site as soon as they are available.

Payor Specification Sheet for MEDICARE PART D/PDP AND MA-PD

PRIME THERAPEUTICS LLC CLIENTS

JANUARY 1, 2006

BIN: See BINs on page 27 (**in bold red type**)

PCN: See PCNs on page 27 (**in bold red type**)

States: Regional

Destination: PRIME/RxClaim

Accepting: Claim Adjudication, Reversals

Format: NCPDP Version 5.1

Prime Contact Center: 800.821.4795

Payor Sheet for Medicare Part D/ PDP and MA-PD

1. SEGMENT AND FIELD REQUIREMENTS BY TRANSACTION TYPE

BILLING (**B1**), REVERSAL (**B2**)
(**M** = Mandatory by HIPAA, **R** = Required by Prime, **S** = Situational, ***V** = Repeat Field)

NOTE: A "**Situational**" data element means the NCPDP Standard does NOT require data on all claims, but the PLAN SPONSOR reserves the possibility of use in specific claim situations. The "**Mandatory**" and "**Required**" fields within a "Situational" segment are only mandatory IF the segment is being utilized.

Situational segments can be transmitted, however, not all segments are supported. Please call the Prime Contact Center at **800.821.4795** for more information regarding the support of claim segments.

- **CONTROLLED SUBSTANCE REPORTING (C1, C2, C3) TRANSACTION DATA ELEMENTS**
  Prime does NOT SUPPORT controlled substance reporting transactions
- **ELIGIBILITY VERIFICATION (E1) TRANSACTION DATA ELEMENTS**
  Prime does NOT SUPPORT eligibility verification transactions – refer to NDC Health
- **PRIOR AUTHORIZATION (P1, P2, P3) TRANSACTION DATA ELEMENTS**
  Prime does NOT SUPPORT prior authorization transactions
- **INFORMATION (N1, N2, N3) TRANSACTION DATA ELEMENTS**
  Prime does SUPPORT informational transactions from and to the TrOOP facilitator

Functionality Highlights

- Compounds segment not supported
- Maximum transaction count is one (1)
- Paper claims (UCFs) will not be accepted from pharmacies that have the capability to adjudicate on-line
- Partial fills are not supported
- Product Service ID Qualifier supported is NDC
- Skilled nursing facilities should be identified by the patient location value

Transaction Header Segment — Mandatory			Segment Is Required
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
101-A1	BIN NUMBER	M	**610455:** Northern Plains Alliance: BCBS of MN, MT, ND, NE, WY, Wellmark BCBS of IA, SD, Employer Groups. Blue Plus Medicare Advantage, BCBS of OK, First Plan, PrimeWest, South Country Health Alliance **011552:** HCSC Insurance Service Corp. (HISC): BCBS of IL, NM, TX, Employer Groups
102-A2	VERSION/RELEASE NUMBER	M	Use **51**
103-A3	TRANSACTION CODE	M	All Plans use **B1, B2**
104-A4	PROCESSOR CONTROL NUMBER	M	**PDP25:** Northern Plains Alliance: BCBS of MN, MT, ND, NE, WY, Wellmark BCBS of IA, SD, PDP Region 25 **PDG25:** Employer Groups, Northern Plains Alliance: BCBS of MN, MT, ND, NE, WY, Wellmark BCBS of IA, SD, PDP Region 25 **MPD19:** Northern Plains Alliance: BCBS of MN, MT, ND, NE, WY, Wellmark BCBS of IA, SD, MA-PD Region 19 **PDPIL:** HISC Insurance Service Corp. (HISC): BCBS of IL, PDP Region 17 **PDGIL:** Employer Groups, HISC Insurance Service Corp. (HISC): BCBS of IL, PDP Region 17 **PDPNM:** BCBS of NM, PDP Region 26 **PDGNM:** Employer Groups, BCBS of NM, PDP Region 26 **PDPTX:** BCBS of TX, PDP Region 22 **PDGTX:** Employer Groups, BCBS of TX, PDP Region 22 **MPDNM:** HISC BCBS of NM, MA-PD Region 20 **MPGNM:** Employer Groups, HISC BCBS of NM, MA-PD Region 20 **MPDTX:** HISC BCBS of TX, MA-PD Region 17

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
			MPGTX: Employer Groups, HISC BCBS of TX, MA-PD Region 17 **PDPOK:** BCBS of OK, PDP Region 23 **PDGOK:** Employer Groups, BCBS of OK, PDP Region 23 **MPDSM:** South Country Health Alliance MSHO **MPDSA:** South Country Health Alliance – AbilityCare **MPDPW:** PrimeWest MSHO **MPDFH:** First Plan of MN **MPDBP:** BCBS of MN, Secure Blue MSHO
109-A9	TRANSACTION COUNT	M	01 – 1 Occurrence
202-B2	SERVICE PROVIDER ID QUALIFIER	M	07 (NCPDP ID)
201-B1	SERVICE PROVIDER ID	M	Value for the qualifier used in 202-B2 above
401-D1	DATE OF SERVICE	M	CCYYMMDD
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	Use value for Switch's requirements. If submitting claim without a Switch, populate with blanks

Patient Segment – Situational			**Client REQUIRES to Locate Correct Member**
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	01 – transmit ONLY if the segment is transmitted
331-CX	PATIENT ID QUALIFIER	S	
332-CY	PATIENT ID	R	
304-C4	DATE OF BIRTH	R	
305-C5	PATIENT GENDER CODE	R	
310-CA	PATIENT FIRST NAME	S	Captured if sent/not required
311-CB	PATIENT LAST NAME	S	Captured if sent/not required
322-CM	PATIENT STREET ADDRESS	S	Captured if sent/not required
323-CN	PATIENT CITY ADDRESS	S	Captured if sent/not required
324-CO	PATIENT STATE/PROVINCE ADDRESS	S	Captured if sent/not required
325-CP	PATIENT ZIP/POSTAL ZONE	S	Captured if sent/not required
326-CQ	PATIENT PHONE NUMBER	S	
307-C7	PATIENT LOCATION	S	Required to submit the values of: 01 – Home Infusion 03 – Nursing Home 05 – Rest Home

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
333-CZ	EMPLOYER ID	S	
334-1C	SMOKER/NON-SMOKER CODE	S	
335-2C	PREGNANCY INDICATOR	S	

Insurance Segment — Situational			Segment Is Required for B1, B2 Transactions
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	04 – transmit ONLY if the segment is transmitted
302-C2	CARDHOLDER ID	M	
312-CC	CARDHOLDER FIRST NAME	S	Captured if sent/not required
313-CD	CARDHOLDER LAST NAME	S	Captured if sent/not required
314-CE	HOME PLAN	S	Captured if sent/not required
524-FO	PLAN ID	S	Captured if sent/not required
309-C9	ELIGIBILITY CLARIFICATION CODE	S	Captured if sent/not required
336-8C	FACILITY ID	S	Captured if sent/not required
301-C1	GROUP ID	S	
303-C3	PERSON CODE	S	
306-C6	PATIENT RELATIONSHIP CODE	S	

Claim Segment — Mandatory			Segment Is Required for B1, B2 Transactions
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	07 – transmit ONLY if the segment is transmitted
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Only value '1' is accepted
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Only supports 7-digit Rx #
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	03
407-D7	PRODUCT/SERVICE ID	M	NDC number
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #	S	
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	S	
458-SE	PROCEDURE MODIFIER CODE COUNT	S	Required ONLY if Procedure Modifier Code submitted
459-ER	PROCEDURE MODIFIER CODE	S	
442-E7	QUANTITY DISPENSED	R	
403-D3	FILL NUMBER	S	
405-D5	DAYS SUPPLY	R	
406-D6	COMPOUND CODE	S	When submitting a compound, submit the value "2" and the NDC value of the most expensive Federal Legend Drug within the compound

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	If null, revert to 0
414-DE	DATE PRESCRIPTION WRITTEN	R	
415-DF	NUMBER OF REFILLS AUTHORIZED	S	
419-DJ	PRESCRIPTION ORIGIN CODE	S	
420-DK	SUBMISSION CLARIFICATION CODE	S	
460-ET	QUANTITY PRESCRIBED	S	Partial fills not supported
308-C8	OTHER COVERAGE CODE	R	
429-DT	UNIT DOSE INDICATOR	S	Not supported
453-EJ	ORIG PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	S	Partial fills not supported
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	S	Partial fills not supported
446-EB	ORIGINALLY PRESCRIBED QUANTITY	S	Partial fills not supported
330-CW	ALTERNATE ID	S	
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	S	
600-28	UNIT OF MEASURE	S	
418-DI	LEVEL OF SERVICE	S	
461-EU	PRIOR AUTHORIZATION TYPE CODE	S	
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	S	
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID	S	
464-EX	INTERMEDIARY AUTHORIZATION ID	S	
343-HD	DISPENSING STATUS	S	Partial fills not supported
344-HF	QUANTITY INTENDED TO BE DISPENSED	S	Partial fills not supported
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	S	Partial fills not supported

Pharmacy Provider Segment — Situational			Segment Is Not Required
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	02 – transmit ONLY if the segment is transmitted
465-EY	PROVIDER ID QUALIFIER	S	
444-E9	PROVIDER ID (NCPDP #)	S	

Prescriber Segment — Situational			Segment Is Required for B1 Transaction
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	03 – transmit ONLY if the segment is transmitted
466-EZ	PRESCRIBER ID QUALIFIER	R	Value – 12
411-DB	PRESCRIBER ID	R	DEA
467-1E	PRESCRIBER LOCATION CODE	S	
427-DR	PRESCRIBER LAST NAME	S	
498-PM	PRESCRIBER PHONE NUMBER	S	

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	S	
421-DL	PRIMARY CARE PROVIDER ID	S	
469-H5	PRIMARY CARE PROVIDER LOCATION CODE	S	
470-4E	PRIMARY CARE PROVIDER LAST NAME	S	

COB/Other Payments Segment — Situational			SUPPORTED – ONLY When Medicare Part D Is Secondary to Commercial Plan, All Fields Required If Other Payor Processed
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	05 – transmit ONLY if the segment is transmitted
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	S	Up to 3 occurrences
338-5C	OTHER PAYOR COVERAGE TYPE	S	Values 01, 02, 03
339-6C	OTHER PAYOR ID QUALIFIER	S	
340-7C	OTHER PAYOR ID	S	
443-E8	OTHER PAYOR DATE	S	CCYYMMDD
341-HB	OTHER PAYOR AMOUNT PAID COUNT	S	
342-HC	OTHER PAYOR AMOUNT PAID QUALIFIER	S***V***	Values 07 – Drug Benefit 08 – Summary of all Reimbursement
431-DV	OTHER PAYOR AMOUNT PAID	S	
471-5E	OTHER PAYOR REJECT COUNT	S	
472-6E	OTHER PAYOR REJECT CODE	S***V***	

Workers' Compensation Segment — Situational			NOT REQUIRED
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	S	06 – transmit ONLY if the segment is transmitted
434-DY	DATE OF INJURY	S	
315-CF	EMPLOYER NAME	S	
316-CG	EMPLOYER STREET ADDRESS	S	
317-CH	EMPLOYER CITY ADDRESS	S	
318-CI	EMPLOYER STATE/PROVINCE ADDRESS	S	
319-CJ	EMPLOYER ZIP/POSTAL ZONE	S	
320-CK	EMPLOYER PHONE NUMBER	S	
321-CL	EMPLOYER CONTACT NAME	S	
327-CR	CARRIER ID	S	
435-DZ	CLAIM/REFERENCE ID	S	

DUR/PPS Segment — Situational			Segment Is Not Required. Use Encouraged If Applicable. Not Required for B2 Transaction.
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	08 – transmit ONLY if the segment is transmitted
473-7E	DUR/PPS CODE COUNTER	S***V***	Required if segment used, 1 to 9 occurrences supported
439-E4	REASON FOR SERVICE CODE	S***V***	Required if segment used
440-E5	PROFESSIONAL SERVICE CODE	S***V***	Required if segment used
441-E6	RESULT OF SERVICE CODE	S***V***	Required if segment used
474-8E	DUR/PPS LEVEL OF EFFORT	S***V***	Required if segment used
475-J9	DUR CO-AGENT ID QUALIFIER	S***V***	Required if 476-H6 used, Values 01, 02, 03, 20
476-H6	DUR CO-AGENT ID	S***V***	Encouraged if code DC, DD, ID, MC, TD in 439-E4

Pricing Segment — Mandatory			Segment Is Required for B1, B2 Transactions
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	11 – transmit ONLY if the segment is transmitted
409-D9	INGREDIENT COST SUBMITTED	R	
412-DC	DISPENSING FEE SUBMITTED	R	
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	S	
433-DX	PATIENT PAID AMOUNT SUBMITTED	S	
438-E3	INCENTIVE AMOUNT SUBMITTED	S	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	S	
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	S***V***	
480-H9	OTHER AMOUNT CLAIMED SUBMITTED	S***V***	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	S	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	S	
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	S	
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	S	
426-DQ	USUAL AND CUSTOMARY CHARGE	R	
430-DU	GROSS AMOUNT DUE	S	
423-DN	BASIS OF COST DETERMINATION	S	

Coupon Segment — Situational			NOT SUPPORTED
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	09 – transmit ONLY if the segment is transmitted
485-KE	COUPON TYPE	S	
486-ME	COUPON NUMBER	S	
487-NE	COUPON VALUE AMOUNT	S	

Compound Segment — Situational			NOT SUPPORTED
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	10 – transmit ONLY if the segment is transmitted
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***V***	
489-TE	COMPOUND PRODUCT ID	M***V***	
448-ED	COMPOUND INGREDIENT QUANTITY	M***V***	
449-EE	COMPOUND INGREDIENT DRUG COST	S***V***	
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	S***V***	

Prior Authorization Segment — Situational			Submit Segment for B1 Transaction Upon Pharmacy Contact Center Request – Not Required for B2
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	12 – transmit ONLY if the segment is transmitted
498-PA	REQUEST TYPE	M	Values 1, 2, 3 accepted
498-PB	REQUEST PERIOD DATE-BEGIN	M	Only stored at this time – Format must be correct, though
498-PC	REQUEST PERIOD DATE-END	M	Only stored at this time – Format must be correct, though
498-PD	BASIS OF REQUEST	M	Values ME, PR, PL accepted
498-PE	AUTHORIZED REPRESENTATIVE FIRST NAME	S	
498-PF	AUTHORIZED REPRESENTATIVE LAST NAME	S	
498-PG	AUTHORIZED REPRESENTATIVE STREET ADDRESS	S	

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
498-PH	AUTHORIZED REPRESENTATIVE CITY ADDRESS	S	
498-PJ	AUTHORIZED REPRESENTATIVE STATE/PROVINCE ADDRESS	S	
498-PK	AUTHORIZED REPRESENTATIVE ZIP/POSTAL ZONE	S	
498-PY	PRIOR AUTHORIZATION NUMBER—ASSIGNED	S	
503-F3	AUTHORIZATION NUMBER	R	
498-PP	PRIOR AUTHORIZATION SUPPORTING DOCUMENTATION	S	

Clinical Segment — Situational			**Not Required. Submit Segment for B1 Transaction ONLY If One or More Specific Fields Are Required for a Specific Claim**
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	13 – transmit ONLY if the segment is transmitted
491-VE	DIAGNOSIS CODE COUNT	S	
492-WE	DIAGNOSIS CODE QUALIFIER	S***V***	
424-DO	DIAGNOSIS CODE	S***V***	
493-XE	CLINICAL INFORMATION COUNTER	S***V***	
494-ZE	MEASUREMENT DATE	S***V***	
495-H1	MEASUREMENT TIME	S***V***	
496-H2	MEASUREMENT DIMENSION	S***V***	
497-H3	MEASUREMENT UNIT	S***V***	
499-H4	MEASUREMENT VALUE	S***V***	

2. GENERAL INFORMATION

- Direct any 5.1 claim production questions to the Prime Contact Center at **800.821.4795**
- Maximum prescriptions per transaction: 1
- Pharmacy Registration with Payor required
- Preferred entry for Prescriber ID is DEA #
- Prime's Switch Support: NDC Health, Emdeon/WebMD, eRx

Payor Specification Sheet for SUPPLEMENTAL TO MEDICARE PART D

PRIME THERAPEUTICS LLC CLIENTS

JANUARY 1, 2006

BIN: See BINs on page 36 (**in bold red type**)

PCN: See PCNs on page 36 (**in bold red type**)

States: National

Destination: PRIME/RxClaim

Accepting: Claim Adjudication, Reversals

Format: NCPDP Version 5.1

Prime Contact Center: 800.821.4795

Payor Sheet for **Supplemental** to Medicare Part D

1. SEGMENT AND FIELD REQUIREMENTS BY TRANSACTION TYPE

BILLING (**B1**), REVERSAL (**B2**), and REBILLING (**B3**) TRANSACTION DATA ELEMENTS
(**M** = Mandatory by HIPAA, **R** = Required by Prime, **S** = Situational, ***V** = Repeat Field)

This Payor Sheet is used when an individual enrolls in Part D and elects to continue their current commercial coverage. Their commercial coverage becomes supplemental to Medicare Part D.

NOTE: A "**Situational**" data element means the NCPDP Standard does NOT require data on all claims, but the PLAN SPONSOR reserves the possibility of use in specific claim situations. The "**Mandatory**" and "**Required**" fields within a "Situational" segment are only mandatory IF the segment is being utilized.

Situational segments can be transmitted, however, not all segments are supported. Please call the Prime Contact Center at **800.821.4795** for more information regarding the support of claim segments.

- **CONTROLLED SUBSTANCE REPORTING (C1, C2, C3) TRANSACTION DATA ELEMENTS**
  Prime does NOT SUPPORT controlled substance reporting transactions
- **ELIGIBILITY VERIFICATION (E1) TRANSACTION DATA ELEMENTS**
  Prime does NOT SUPPORT eligibility verification transactions – refer to NDC Health
- **PRIOR AUTHORIZATION (P1, P2, P3) TRANSACTION DATA ELEMENTS**
  Prime does NOT SUPPORT prior authorization transactions
- **INFORMATION (N1, N2, N3) TRANSACTION DATA ELEMENTS**
  Prime does SUPPORT informational transactions from and to the TrOOP facilitator

Functionality Highlights

- COB segment supported
- Maximum transaction count is one (1)
- Note unique PCNs for this commercial business; Prime's web site, **www.primetherapeutics.com**, will be updated as new processing information becomes available
- Paper claims (UCFs) will not be accepted from pharmacies that have the capability to adjudicate on-line
- Partial fills are not supported

Payor Specification Sheet for SUPPLEMENTAL TO MEDICARE PART D (Page 2 of 9)

Transaction Header Segment — Mandatory			Segment Is Required
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
101-A1	BIN NUMBER	M	**610455:** BCBS of MN, ND, NE **011552:** BCBS of IL, NM, TX **800001:** BCBS of WY
102-A2	VERSION/RELEASE NUMBER	M	Use 51
103-A3	TRANSACTION CODE	M	All Plans use B1, B2. Note: Only BCBS of MN uses B3
104-A4	PROCESSOR CONTROL NUMBER	M	**PGSUP:** BCBS of MN **NESUP:** BCBS of NE HMO **NDSUP:** BCBS of ND **WYSUP:** BCBS of WY BCBS of IL BCBS of NM BCBS of TX
109-A9	TRANSACTION COUNT	M	01 – 1 Occurrence
202-B2	SERVICE PROVIDER ID QUALIFIER	M	07 (NCPDP ID) or 13 (State Issued)
201-B1	SERVICE PROVIDER ID	M	Value for the qualifier used in 202-B2 above
401-D1	DATE OF SERVICE	M	CCYYMMDD
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	Use value for Switch's requirements. If submitting claim without a Switch, populate with blanks

This Payor Sheet will be updated on Prime's web site as processing information becomes available.

Patient Segment – Situational			Client REQUIRES Segment for B1, B2, and B3 Transactions to Locate Correct Member
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	01 – transmit ONLY if the segment is transmitted
331-CX	PATIENT ID QUALIFIER	S	Required for Worker's Comp
332-CY	PATIENT ID	R	Required for Worker's Comp
304-C4	DATE OF BIRTH	R	
305-C5	PATIENT GENDER CODE	R	

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
310-CA	PATIENT FIRST NAME	R	
311-CB	PATIENT LAST NAME	S	Captured if sent/not required
322-CM	PATIENT STREET ADDRESS	S	Captured if sent/not required
323-CN	PATIENT CITY ADDRESS	S	Captured if sent/not required
324-CO	PATIENT STATE/PROVINCE ADDRESS	S	Captured if sent/not required
325-CP	PATIENT ZIP/POSTAL ZONE	S	Captured if sent/not required
326-CQ	PATIENT PHONE NUMBER	S	Captured if sent/not required
307-C7	PATIENT LOCATION	S	
333-CZ	EMPLOYER ID	S	
334-1C	SMOKER/NON-SMOKER CODE	S	
335-2C	PREGNANCY INDICATOR	S	

Insurance Segment — Situational			**Segment Is Required for B1 and B3 Transactions. Not Required for B2 Transaction**
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	01 – transmit ONLY if the segment is transmitted
302-C2	CARDHOLDER ID	M	
312-CC	CARDHOLDER FIRST NAME	S	Captured if sent/not required
313-CD	CARDHOLDER LAST NAME	S	Captured if sent/not required
314-CE	HOME PLAN	S	Captured if sent/not required
524-FO	PLAN ID	S	Captured if sent/not required
309-C9	ELIGIBILITY CLARIFICATION CODE	S	Captured if sent/not required
336-8C	FACILITY ID	S	Captured if sent/not required
301-C1	GROUP ID	R	
303-C3	PERSON CODE	S	
306-C6	PATIENT RELATIONSHIP CODE	S	

Claim Segment — Mandatory			**Segment Is Required for B1, B2, B3 Transactions**
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	07 – transmit ONLY if the segment is transmitted
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Only value '1' is accepted
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Only supports 7-digit Rx #
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	03
407-D7	PRODUCT/SERVICE ID	M	NDC number

Payor Specification Sheet for SUPPLEMENTAL TO MEDICARE PART D (Page 4 of 9)

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #	S	
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	S	
458-SE	PROCEDURE MODIFIER CODE COUNT	S	Required ONLY if Procedure Modifier Code submitted
459-ER	PROCEDURE MODIFIER CODE	S	
442-E7	QUANTITY DISPENSED	R	
403-D3	FILL NUMBER	S	
405-D5	DAYS SUPPLY	R	
406-D6	COMPOUND CODE	S	When submitting a compound, submit the value "2" and the NDC value of the most expensive Federal Legend Drug within the compound
408-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	If null, revert to 0
414-DE	DATE PRESCRIPTION WRITTEN	R	
415-DF	NUMBER OF REFILLS AUTHORIZED	S	
419-DJ	PRESCRIPTION ORIGIN CODE	S	
420-DK	SUBMISSION CLARIFICATION CODE	S	
460-ET	QUANTITY PRESCRIBED	S	Partial fills not supported
308-C8	OTHER COVERAGE CODE	R	
429-DT	UNIT DOSE INDICATOR	S	
453-EJ	ORIG PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	S	Partial fills not supported
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	S	Partial fills not supported
446-EB	ORIGINALLY PRESCRIBED QUANTITY	S	Partial fills not supported
330-CW	ALTERNATE ID	S	
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	S	
600-28	UNIT OF MEASURE	S	Not supported
418-DI	LEVEL OF SERVICE	S	
461-EU	PRIOR AUTHORIZATION TYPE CODE	S	
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	S	
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID	S	
464-EX	INTERMEDIARY AUTHORIZATION ID	S	
343-HD	DISPENSING STATUS	S	Partial fills not supported
344-HF	QUANTITY INTENDED TO BE DISPENSED	S	Partial fills not supported
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	S	Partial fills not supported

Pharmacy Provider Segment — Situational			Segment Is Not Required
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	02 – transmit ONLY if the segment is transmitted
465-EY	PROVIDER ID QUALIFIER	S	
444-E9	PROVIDER ID (NCPDP #)	S	

Prescriber Segment — Situational			Segment Is Required for B1 and B3 Transaction
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	03 – transmit ONLY if the segment is transmitted
466-EZ	PRESCRIBER ID QUALIFIER	R	
411-DB	PRESCRIBER ID	R	
467-1E	PRESCRIBER LOCATION CODE	S	
427-DR	PRESCRIBER LAST NAME	S	
498-PM	PRESCRIBER PHONE NUMBER	S	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	S	
421-DL	PRIMARY CARE PROVIDER ID	S	
469-H5	PRIMARY CARE PROVIDER LOCATION CODE	S	
470-4E	PRIMARY CARE PROVIDER LAST NAME	S	

COB/Other Payments Segment — Situational			Required
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	05 – transmit ONLY if the segment is transmitted
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	R	Up to 3 occurrences
338-5C	OTHER PAYOR COVERAGE TYPE	R	Values 01 – Primary 02 – Secondary 03 – Tertiary
339-6C	OTHER PAYOR ID QUALIFIER	R	
340-7C	OTHER PAYOR ID	R	
443-E8	OTHER PAYOR DATE	R	CCYYMMDD
341-HB	OTHER PAYOR AMOUNT PAID COUNT	R	

NCPDP Field	Field Name	Mandatory, Required, or Situational	Comments/Values
342-HC	OTHER PAYOR AMOUNT PAID QUALIFIER	R	Values 07 – Drug benefit 08 – Summary of all reimbursement
431-DV	OTHER PAYOR AMOUNT PAID	R	Required if other payor paid
471-5E	OTHER PAYOR REJECT COUNT	R	Required if other payor paid
472-6E	OTHER PAYOR REJECT CODE	R	Required if other payor paid

Workers' Compensation Segment — Situational			Segment Is Not Required. Not Required for B2 Transaction
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	06 – transmit ONLY if the segment is transmitted
434-DY	DATE OF INJURY	M	
315-CF	EMPLOYER NAME	S	
316-CG	EMPLOYER STREET ADDRESS	S	
317-CH	EMPLOYER CITY ADDRESS	S	
318-CI	EMPLOYER STATE/PROVINCE ADDRESS	S	
319-CJ	EMPLOYER ZIP/POSTAL ZONE	S	
320-CK	EMPLOYER PHONE NUMBER	S	
321-CL	EMPLOYER CONTACT NAME	S	
327-CR	CARRIER ID	S	
435-DZ	CLAIM/REFERENCE ID	S	

DUR/PPS Segment — Situational			Segment Is Not Required. Use Encouraged if applicable. Not Required for B2 transaction
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	08 – transmit ONLY if the segment is transmitted
473-7E	DUR/PPS CODE COUNTER	S***V***	Required if segment used, 1 to 9 occurrences supported
439-E4	REASON FOR SERVICE CODE	S***V***	Required if segment used
440-E5	PROFESSIONAL SERVICE CODE	S***V***	Required if segment used
441-E6	RESULT OF SERVICE CODE	S***V***	Required if segment used
474-8E	DUR/PPS LEVEL OF EFFORT	S***V***	Required if segment used
475-J9	DUR CO-AGENT ID QUALIFIER	S***V***	Required if 476-H6 used. Values 01, 02, 03, 20
476-H6	DUR CO-AGENT ID	S***V***	Encouraged if code DC, DD, ID, MC, TD in 439-E4

Pricing Segment — Mandatory			Segment Is Required for B1 and B3 Transactions. Not Required for B2 Transaction
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	11 – transmit ONLY if the segment is transmitted
409-D9	INGREDIENT COST SUBMITTED	R	
412-DC	DISPENSING FEE SUBMITTED	R	
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	S	
433-DX	PATIENT PAID AMOUNT SUBMITTED	S	
438-E3	INCENTIVE AMOUNT SUBMITTED	S	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	S	
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	S***V***	
480-H9	OTHER AMOUNT CLAIMED SUBMITTED	S***V***	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	S	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	S	
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	S	
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	S	
426-DQ	USUAL AND CUSTOMARY CHARGE	R	
430-DU	GROSS AMOUNT DUE	S	
423-DN	BASIS OF COST DETERMINATION	S	

Coupon Segment — Situational			Required in B1 and B3 Transactions ONLY If Coupons Apply to the Claim. Not Required for B2 Transaction
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	09 – transmit ONLY if the segment is transmitted
485-KE	COUPON TYPE	M	Required if segment used
486-ME	COUPON NUMBER	M	Required if segment used
487-NE	COUPON VALUE AMOUNT	S	

Compound Segment — Situational			NOT SUPPORTED
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	10 – transmit ONLY if the segment is transmitted
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***V***	
489-TE	COMPOUND PRODUCT ID	M***V***	
448-ED	COMPOUND INGREDIENT QUANTITY	M***V***	
449-EE	COMPOUND INGREDIENT DRUG COST	S***V***	
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	S***V***	

Prior Authorization Segment — Situational			Submit Segment for B1 and B3 Transaction Upon Pharmacy Contact Center Request. Not Required for B2 Transaction
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	12 – transmit ONLY if the segment is transmitted
498-PA	REQUEST TYPE	M	Values 1, 2, 3 accepted
498-PB	REQUEST PERIOD DATE-BEGIN	M	Only stored at this time. Format must be correct, though
498-PC	REQUEST PERIOD DATE-END	M	Only stored at this time. Format must be correct, though
498-PD	BASIS OF REQUEST	M	Values ME, PR, PL accepted
498-PE	AUTHORIZED REPRESENTATIVE FIRST NAME	S	
498-PF	AUTHORIZED REPRESENTATIVE LAST NAME	S	
498-PG	AUTHORIZED REPRESENTATIVE STREET ADDRESS	S	
498-PH	AUTHORIZED REPRESENTATIVE CITY ADDRESS	S	
498-PJ	AUTHORIZED REPRESENTATIVE STATE/PROVINCE ADDRESS	S	
498-PK	AUTHORIZED REPRESENTATIVE ZIP/POSTAL ZONE	S	
498-PY	PRIOR AUTHORIZATION NUMBER—ASSIGNED	S	
503-F3	AUTHORIZATION NUMBER	R	
498-PP	PRIOR AUTHORIZATION SUPPORTING DOCUMENTATION	S	

Clinical Segment — Situational			Not Required. Submit Segment for B1 or B3 Transaction ONLY If One or More Specific Fields Are Required for a Specific Claim
NCPDP Field	**Field Name**	**Mandatory, Required, or Situational**	**Comments/Values**
111-AM	SEGMENT IDENTIFICATION	M	13 – transmit ONLY if the segment is transmitted
491-VE	DIAGNOSIS CODE COUNT	S	
492-WE	DIAGNOSIS CODE QUALIFIER	S***V***	
424-DO	DIAGNOSIS CODE	S***V***	
493-XE	CLINICAL INFORMATION COUNTER	S***V***	
494-ZE	MEASUREMENT DATE	S***V***	
495-H1	MEASUREMENT TIME	S***V***	
496-H2	MEASUREMENT DIMENSION	S***V***	
497-H3	MEASUREMENT UNIT	S***V***	
499-H4	MEASUREMENT VALUE	S***V***	

2. GENERAL INFORMATION

- Direct any 5.1 claim production questions to the Prime Contact Center at **800.821.4795**
- Maximum prescriptions per transaction: 1
- Pharmacy Registration with Payor required
- Preferred entry for Prescriber ID is DEA #
- Prime provides on-line prospective DUR edits for all of its plans.
  Call the Prime Contact Center at **800.821.4795** for further information
- Prime's Switch Support: NDC Health, Emdeon/WebMD, eRx

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