Provider Manual

CVS caremark®

Dear Pharmacy Provider,

Welcome to the 2026 Caremark Provider Manual.

Caremark appreciates the role that its Providers play in delivering vital, high-quality care across the country. The 2026 Caremark Provider Manual ("Provider Manual") contains the policies and procedures that Providers must adhere to in servicing Caremark Eligible Persons. This Provider Manual is an essential component of the Caremark Provider Agreement and is incorporated by reference into your Caremark Provider Agreement. Please note, the 2026 Provider Manual supersedes and replaces all prior versions of the Provider Manual.

Please refer to the Table of Contents for a summary of the topics covered in the Provider Manual. It is incumbent upon you to understand the requirements in the Provider Manual, ensure that your pharmacy staff are properly trained on these policies and procedures, and monitor and comply with all amendments and updates.

Should you have any questions about this Provider Manual, please reach out via the contact information provided in the chapter relevant to your topic of inquiry.

Caremark looks forward to partnering with you as you continue to provide high-quality health care services to Caremark Eligible Persons.

Thank you.

Table of Contents

1. General Information **6**

1.01 Proprietary Statement 6
1.02 Provider Manual Breaches 6
1.03 Contacting Caremark 6
1.03.01 Pharmacy Help Desk 6
1.03.02 Additional Resources 7
1.04 Pharmacy Communications 7
1.05 CVS Caremark Pharmacy Portal 7
1.05.01 Pharmacy Portal Terms of Use 8
1.06 Questions Asked by Providers 8
1.06.01 Pharmacy Audit and Pharmacy Compliance 8
1.06.02 Network Contract Rates/Terms 9
1.06.03 Provider Enrollment, Credentialing, Change of Ownership 9
1.06.04 Claims Processing and Benefit Plan Design 10

2. Credentialing **12**

2.01 Provider Credentialing 12
2.02 Steps to Become a Provider 12
2.02.01 Review Credentialing Requirements 13
2.02.02 Complete the "Pharmacy Pre-Enrollment Questionnaire" 14
2.02.03 Create a Pharmacy Portal Account to Submit Enrollment Application 14
2.02.04 Complete and Submit Your Application 14
2.02.05 Additional Application Requirements for Pharmacies Located in a Strike Force Location 15
2.02.06 Additional Application Requirements for Dispensing Practitioners 15
2.03 Steps to Become a Complex Compound Provider 16
2.04 Plan Sponsor Networks 16
2.05 Notification to Caremark 17
2.05.01 Notification of Change in Documentation and Other Information 17
2.05.02 Notification of Closure 17
2.06 Change in Ownership 17
2.07 Recredentialing 18
2.08 Reporting of Investigations and Disciplinary Actions 19
2.09 Criminal Offense Related to Federal Health Care Programs 19
2.09.01 Pharmacy Criminal Offense 19
2.09.02 Prescriber Criminal Offense 20
2.10 Federal Health Care Programs Participation Exclusion: Pharmacy 20

3. Pharmacy Services and Standards **21**

3.01 Providing Pharmacy Services to Eligible Persons 21
3.01.01 Professional Judgment and Conduct 21
3.01.02 Verification of Eligible Persons 21
3.01.03 Identification Cards 21
3.01.04 Nondiscrimination 21
3.01.05 Eligible Person Solicitation 21
3.01.06 Eligible Person Complaints 21
3.01.07 Patient Receipts and Insurance Profiles 21
3.01.08 Educational Materials and Efforts 22
3.02 Dispensing Requirements 22
3.02.01 Hours of Operation 22
3.02.02 Drug Stock and Inventory 22
3.02.03 Aberrant Practices and Trends 22
3.02.04 Dispensing Covered Items to Eligible Person's Agent 22
3.02.05 Performance Initiatives 23
3.02.06 Dispensing Errors 23
3.03 Patient Pay 23
3.03.01 Collection of Patient Pay Amounts 23
3.03.02 Usual and Customary Price 23
3.03.03 Coupons and Other Programs 24
3.03.04 Proof of Payment 24
3.03.05 Excess Collections 25
3.03.06 Limitation on Collection 25
3.03.07 Patient Inducements 25
3.03.08 Waivers 25
3.03.09 Financial Hardship Program 25
3.03.10 Documentation 26
3.03.11 Violations 26
3.04 Standards of Operation 26
3.04.01 Other Standards of Operations 27
3.05 Records 27
3.05.01 Documents and Records Maintenance 27

TABLE OF CONTENTS

3.05.02 Signature Log – Hard Copy or Electronic 27
3.05.03 Prescription Information 28
3.06 Referrals 29
3.06.01 Referral Fees 29
3.06.02 Referrals to Non-Retail Participating Providers 29

4. Claims Submission 30

4.01 Payer Sheets and Reject Codes 30
4.02 General Claim Submission Policies 30
4.03 Other Claim Submission Requirements 31
4.04 Dispense as Written Codes 33
4.05 Usual and Customary Validation 34
4.06 Over-the-Counter Products 34
4.07 Multi-Ingredient Compound Processing 34
4.08 Overrides 37
4.09 Natural Disasters 37
4.10 Coordination of Benefits 37
4.10.01 Multiple Transaction Coordination of Benefits 37
4.10.02 Single Transaction Coordination of Benefits 38
4.11 Long-Term Care Billing 38
4.12 Dispensing Pharmacy NPI/NCPDP 38
4.13 Prescriber Identification; Prescriptive Authority 38
4.14 Transaction Fees 38
4.15 Electronic Submission, Reversal, and Processing Windows 39
4.15.01 Universal Claim Form Requirement 39
4.16 Software Certification 39
4.17 Schedule of Claim Adjudication Systems Maintenance 40
4.17.01 Additional Required Procedures 40
4.18 Provider Taxes 40

5. Clinical Programs, Services and Related Messages 42

5.01 Drug Utilization Review 42
5.02 Drug Utilization Review Conflict Codes and Messaging 42
5.03 Refill-Too-Soon or Excessive Utilization Reject 42
5.04 Drug-Drug Interaction Reject Program 43
5.05 Formularies 43
5.06 Prior Authorization 43
5.07 Managed Drug Limitations/ Quantity vs. Time 44
5.08 Dose Optimization 44
5.09 Step Therapy 45
5.10 Plan Sponsor Programs 45
5.11 Federal Regulatory Quality Assurance Programs 45
5.12 Clinical Studies/Trials 45
5.13 Vaccines and Medication Administration 46

6. Network Participation and Payment 47

6.01 Network Participation 47
6.02 Provider Payment 47
6.02.01 General Reimbursement 47
6.02.02 Multi-Ingredient Compound Reimbursement 47
6.02.03 Vaccine and Non-Vaccine Injectable Administration Reimbursement 48
6.02.04 Adjustments to Reimbursement 48
6.02.05 Post-Adjudication Settlements 48
6.02.06 Other Entity Adjudication 49
6.03 Changes to Average Wholesale Price 49
6.04 Maximum Allowable Cost 49
6.05 Eligible Person Fees and Amounts 50
6.06 Claims Payment and Other Fees 50
6.06.01 Remittance Advices 50
6.06.02 Disputed Claims, Collected Fees, Amounts, or Recoupments 50
6.06.03 Claim Adjustment 50
6.07 Recoupment and Adjustments 51
6.08 Workers' Compensation 51
6.09 Consumer Card 51
6.10 Provider Suspension 51
6.11 Directories 52
6.12 Collection of Regulatory or Other Governmental Agency Assessment 52

7. Compliance Reviews 53

7.01 Types of Compliance Reviews 53
7.02 Non-Compliance Charges 53
7.03 Additional Information Regarding Compliance Reviews 54

TABLE OF CONTENTS

8. Professional Audits **55**

8.01 Types of Audits 55
8.01.01 On-Site Audits 55
8.01.02 Expanded Audits 55
8.01.03 Desktop Audits 55
8.01.04 Audits by Government Agencies 55
8.02 Professional Audits Rights 55
8.03 Documents and Records Production Related to Audits 56
8.04 Documents and Records Subject to Audit 57
8.05 Supply of Covered Items; Purchase Invoices 58
8.05.01 Invoice Documents and Records Maintenance 59
8.06 Medicare Part D Requirements 59
8.07 On-Site and Expanded Audit Resolution – Appeals Process 60
8.08 Corrective Action Plan 61
8.09 Potentially Fraudulent Activity 61

9. Medicaid **62**

9.01 Compliance with State and Federal Laws 62
9.02 Enrollment with State Medicaid 62
9.03 Medicaid Credentialing 62
9.04 Fraud, Waste and Abuse Compliance Program 62
9.05 Inspection and Audit of Records and Access to Facilities 62
9.06 Claims Submission Requirements for Medicaid 63
9.06.01 Unique RXBIN/RXPCN (or RXIIN/RXPCN) Requirement for Medicaid 63
9.07 Medicaid Coordination of Benefits 63
9.08 Prior Authorization 63
9.09 Denial of Services 63
9.10 Cultural Competency 63
9.11 Home Delivery 63
9.12 Directories 63
9.13 Overpayment 63
9.14 Transition Fill 64

10. Medicare Part D **65**

10.01 Medicare Part D Network Standards 65
10.01.01 Network Participation 65
10.01.02 Compliance with Laws 65
10.01.03 Delegated Activity 65
10.01.04 Offshore Subcontracting 66
10.01.05 Marketing 66
10.01.06 Pharmacy Compliance and Fraud, Waste and Abuse Program 66
10.01.07 Pharmacy Compliance and Fraud, Waste and Abuse Training 66
10.01.08 CMS-10147 Pharmacy Notice 66
10.01.09 Performance Monitoring 67
10.02 General Information 67
10.02.01 Part D Reference Information for Pharmacists 67
10.02.02 Medicare Part D Calls to the Pharmacy Help Desk 67
10.03 Credentialing 67
10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies 67
10.03.02 Federal Health Care Programs Participation Exclusion 68
10.04 Pharmacy Services and Standards 68
10.04.01 Plan Identification Cards 68
10.04.02 General Procedures for Acknowledgement of Enrollment Letters 68
10.04.03 Best Available Evidence 69
10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in Low-Income Subsidy 70
10.04.05 Auto-Ship Refill Programs 70
10.05 Claims Submission 70
10.05.01 Unique RXBIN/RXPCN (or RXIIN/RXPCN) Requirement - Medicare Part D 70
10.05.02 Payment of Clean Claims 70
10.05.03 Electronic Prescribing 70
10.05.04 Prescription Origin Code and Fill Number 71
10.05.05 Improving Drug Utilization Review Controls 71
10.05.06 Medicare Part D Claims Requiring Overrides 73
10.05.07 General Medicare Part D Submission Requirements for Coordination of Benefits 73
10.05.08 Formulary Transition Fill Process 74
10.05.09 Insulin Coverage 75
10.05.10 Pro-Rated Daily Cost Share 75
10.05.11 Medicare Part B and Medicare Part D Coverage Determinations 76

10.05.12 End Stage Renal Disease Claim Processing 76
10.05.13 Prescriber Identification for Medicare Part D Claims 76
10.05.14 Claims Submission Window for Medicare Part D 77
10.05.15 Medicare Part D Claim Adjustment 78
10.05.16 Medicare Part D Transaction Fees 78
10.05.17 Medicare Part B 90-Day Transition Period 78
10.06 Network Participation and Payment 79
10.06.01 Product Pricing 79
10.06.02 Pharmacy Service Type and Patient Residence Requirements 79
10.07 Special Instructions for Participating Long-Term Care Providers 80
10.07.01 Pharmacies Serving LTC Facilities 80
10.07.02 LTC Pharmacies Timely Claim Submission 80
10.07.03 LTC Appropriate Days' Supply Short Cycle Billing 80
10.07.04 LTC Days' Supply Limitations 81
10.07.05 LTC Transition Fill 81
10.07.06 Special Packaging Indicator 83
10.07.07 LTC Override Requests 83
10.07.08 Medicare Part A and Medicare Part D Drug Coverage Determinations 85
10.08 Medicare Prescription Payment Plan 86
10.08.01 Payments 86
10.08.02 Claims 86
10.08.03 Coordination of Benefits 87
10.09 Medicare Drug Price Negotiation 87
10.10 Retail Addendum to the Caremark Provider Agreement 88

11. Medicare Advantage 91

12. Qualified Health Plans 93

13. Intellectual Property, Confidentiality and Proprietary Rights 94

13.01 Advertising and Trademarks 94
13.02 Non-Disparagement 94
13.03 Confidentiality 94
13.04 Non-Solicitation and Non-Interference 95
13.05 Proprietary Rights 95
13.06 Remedies 96

14. Miscellaneous 97

14.01 Assignment 97
14.02 Independent Contractors and Third-Party Beneficiaries 97
14.03 Court Orders, Subpoenas or Governmental Requests 97
14.04 Notices 97
14.05 Termination 98
14.05.01 Termination for Cause 98
14.05.02 Termination Without Cause 99
14.05.03 Rights and Remedies in the Event of Termination or Breach 99
14.06 Survival of Certain Provisions 99
14.07 Amendments 100
14.08 Enforceability 100
14.09 Arbitration 100
14.09.01 Discovery Limitations 101
14.09.02 Expenses of Arbitration 101
14.09.03 Anti-Class; Anti-Consolidation of Claims in Arbitration 101
14.09.04 Confidentiality of Arbitration 102
14.09.05 No Collateral Estoppel/Precedential Impact of Award 102
14.09.06 Waiver of Right to Confirm Award Upon Payment 102
14.09.07 Dispute Resolution Procedures 102
14.09.08 Severability 103
14.10 Force Majeure 103
14.11 Anti-Kickback Statute, Stark Law and Caremark Compliance Program 103
14.12 Rebate Programs 103
14.13 Eligible Person Communications 103

15. Federal and State Laws and Regulations 104

15.01 Compliance with Laws 104

Appendix A - Appeals Process Documentation Guidelines 105

Glossary of Terms 111

1. General Information

This 2026 Provider Manual supersedes and replaces all prior versions of the Provider Manual. As a network Provider, you are responsible for monitoring and complying with all changes to the Provider Manual. Capitalized terms used in the Provider Manual not defined in the **Glossary of Terms** in the Provider Manual shall have the same meaning as in the Provider Agreement.

Provider acknowledges that Caremark Rx, L.L.C., together with certain other designated affiliates of Caremark Rx, L.L.C., including, but not limited to, CVS Caremark® Part D Services, L.L.C., shall be referred to collectively as, "Caremark" for the purposes of this Provider Manual.

1.01 Proprietary Statement

The Provider Agreement (which includes the Provider Manual, Appendices, Glossary, CVS Caremark Provider Manual State Addenda) constitutes Confidential Caremark Information and is provided to Provider for business purposes only. Provider must maintain in confidence the Provider Manual, and must not disclose, sell, assign, transfer, or give to any third party the Provider Manual or any of its contents without Caremark's prior written consent. All payer sheets are part of the Provider Agreement and are incorporated into the Provider Agreement pursuant to the terms thereof. Refer to section **13.03 Confidentiality** of the Provider Manual.

1.02 Provider Manual Breaches

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches the Provider Agreement, which includes the Provider Manual and terms and conditions outlined herein, CVS Caremark Provider Manual State Addenda (available on the Pharmacy Portal), and other Caremark Documents, Caremark may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including Chargeback of applicable claims.

Individual violations of the Provider Manual each may constitute a separate basis for Caremark's decision to terminate the Provider Agreement. Violations of different provisions of the Provider Manual individually or collectively may subject Providers to termination of the Provider Agreement. In the event Provider breaches any terms and conditions outlined in the Provider Manual, Provider may not seek reimbursement from Eligible Person(s), and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks).

Refer to section **14.05.01 Termination for Cause** and chapter **15. Federal and State Laws and Regulations** of the Provider Manual.

1.03 Contacting Caremark

Caremark strives to ensure that Providers receive prompt and courteous assistance with questions. For questions on specific topics, Provider can contact Caremark using the contact instructions provided in the relevant Provider Manual section or in a specific pharmacy communication.

Unless otherwise specified in the Provider Manual, Providers can send general inquiries to the below address:

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

1.03.01 Pharmacy Help Desk

Caremark's Pharmacy Help Desk representatives are available every day of the year. The Interactive Voice Response (IVR) system is available 24 hours a day, 7 days a week, excluding downtime for maintenance and service. Pharmacy Help Desk phone numbers and associated Bank Identification Numbers (RXBIN) or Issuer Identification Numbers (RXIIN) are found at **caremark.com/pharminfo**.

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

Refer to section **10.02 General Information** of the Provider Manual for details on Medicare Part D calls to the Pharmacy Help Desk.

1.03.02 Additional Resources

The following additional resources are always available to Providers at **caremark.com/pharminfo**:

- Information and FAQs
- Forms and Guides
- Medicare and Medicaid Compliance Training
- Provider Credentialing
- National Council for Prescription Drug Programs (NCPDP) Payer Sheets [A payer sheet provides information necessary to electronically submit pharmacy point-of-sale (POS) claims. This includes NCPDP Telecommunication Standard Segments, Fields, and ECL values that Caremark requires for claim adjudication.]

1.04 Pharmacy Communications

Caremark may communicate to Providers, and Provider agrees to receive pharmacy communications and other important information, via email, fax, telephone, UPS (or other carrier), USPS, or secure messages through the CVS Caremark Pharmacy Portal ("Pharmacy Portal"), as permitted by applicable Law. Pharmacy communications may require an action by Provider in response to the communication. Pharmacy communications include but are not limited to:

- Provider Manual and Provider Manual Amendments
- Plan Sponsor implementation notices
- Formulary updates
- Clinical/vaccine information
- Pharmacy audit tips
- Medicare Part D or other government or regulatory guidance
- Network initiatives
- Industry standard changes
- Emergency procedures
- Plan Sponsor initiatives
- Point-of-service issues
- Network enrollment forms or other contract updates

Caremark pharmacy communications are considered a Caremark Document within the meaning of the Provider Manual and may not be subject to opt-out requests.

It is Provider's responsibility to promptly notify Caremark of any changes to Provider's contact information, including street address, mailing address, phone number, fax number, or email address. Provider's failure to update its contact information with Caremark, or refusal to accept delivery of a communication from Caremark via any method of delivery, shall not relieve Provider of any obligations to comply with the information communicated. Refer to sections **2.05.01 Notification of Change in Documentation and Other Information** and **14.04 Notices** of the Provider Manual.

1.05 CVS Caremark Pharmacy Portal

Caremark provides online access to information via its CVS Caremark Pharmacy Portal ("Pharmacy Portal") at **rxservices.cvscaremark.com**. The information provided in the Pharmacy Portal is Caremark's confidential and proprietary information and considered "Confidential Caremark Information" as this term is defined in the **Glossary of Terms** in the Provider Manual. Pursuant to the terms of the Caremark Provider Manual, you may not disclose, sell, assign, transfer, or give the information contained therein to any third party.

In states where electronic communication requirements exist, Providers are required to create a Pharmacy Portal account to access secure messages and view Caremark Documents. Provider's failure to create a Pharmacy Portal account, or refusal to review secure messages or Caremark Documents on the Pharmacy Portal, shall not relieve Provider of any obligations to comply with the information communicated.

Provider may log in to the Pharmacy Portal to access information and other services Caremark may make available. Provider acknowledges that the Pharmacy Portal is an effective medium for communicating Caremark Documents. Provider is required to frequently log in to the Pharmacy Portal to review important information to ensure awareness of Caremark requirements including, but not limited to: Provider Manual amendments; network enrollment forms; network initiatives with performance, clinical, or health care outcome measures; vaccine requirements; Medicare Part D regulations; and Medicaid/state regulations.

Independent or affiliated-independent providers will be prompted to set a unique username and password as part of the initial login process. Detailed provider-specific account information must be entered as part of the initial login process including, but not limited to, pharmacy NCPDP number (seven digits), pharmacy National Provider Identifier (NPI), state license number, Drug Enforcement Administration (DEA) number, and Federal Employer ID Number (FEIN).

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

Provider is responsible for all actions of representatives to whom Provider has granted Pharmacy Portal access. Provider is obligated to remove access to the Pharmacy Portal when those representatives no longer have a bona-fide need for such access, e.g., upon employment termination or change in assigned duties. Caremark, in its sole discretion, may terminate Pharmacy Portal access after 180 days of inactivity. Instructions for managing Pharmacy Portal accounts can be found in the Document Library, "Pharmacy Portal" folder, "Account Maintenance".

Caremark may, in its sole discretion, provide additional Pharmacy Portal functionality to Providers as outlined in other network-related contractual arrangements.

For troubleshooting the Pharmacy Portal registration and/or login process only, please provide your NCPDP, Pharmacy Portal User ID, and your full name in an email to **RxServices@CVSHealth.com**. If you are a chain or PSAO, contact your network account manager.

1.05.01 Pharmacy Portal Terms of Use

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

The Pharmacy Portal may provide authorized users with various analytical tools (including, but not limited to, MAC Price Lookup, Submit Appeals, Load Medicare Part D Drug MAC Updates). The Pharmacy Portal, and its content, are the property of Caremark and users are strictly prohibited from using Pharmacy Portal content or information for any purpose other than for the purposes of fulfilling the Provider's obligations under the Provider Agreement. Users are strictly prohibited from accessing the Pharmacy Portal using automated means (such as harvesting bots, robots, spiders, or scrapers). Caremark reserves the right to remove content from the Pharmacy Portal at its sole and absolute discretion. Improper use or unauthorized access of the Pharmacy Portal may result in termination of Pharmacy Portal use privileges and pursuit of all other remedies available to Caremark.

1.06 Questions Asked by Providers

1.06.01 Pharmacy Audit and Pharmacy Compliance

1. **My pharmacy has received notice of an upcoming pharmacy audit. How do I request an extension to the audit date?**

   If your pharmacy received notice of an impending pharmacy audit, please refer to the letter you received which includes contact information for the pharmacy auditor that will be conducting the audit. Please reach out to the pharmacy auditor directly to request an extension.

2. **My pharmacy just received an <u>initial</u> discrepancy list from a recent pharmacy audit. Can I request an extension? What are my next steps?**

   Yes. If your pharmacy needs additional time, reach out to the contact listed in the correspondence to inquire if your pharmacy can be granted a short extension.

3. **How can I address the initial discrepancies from my pharmacy's recent audit?**

   Reference **Appendix A – Appeals Process Documentation Guidelines** of the Provider Manual for a description of the discrepancy type and acceptable documentation required to support a potential resolution of the identified discrepancies.

4. **My pharmacy just received a <u>final</u> discrepancy list from a recent pharmacy audit. Can I request an extension?**

   Once the final audit discrepancy list is complete, the pharmacy will need to engage in the dispute resolution process to contest the audit discrepancy list. Refer to section **14.09 Arbitration** of the Provider Manual.

5. Can adverse audit findings result in my pharmacy being terminated?

Yes. Pharmacies that have adverse audit findings may be presented to an internal review committee that may determine to terminate your pharmacy from a Caremark network(s) or elect to terminate your pharmacy Provider Agreement.

6. I am considering using a new distributor. What are some best practices that I should use when making the decision?

Selection of a supplier is extremely important for any pharmacy as you need products that are safe and unadulterated and that will have a potential positive impact on the health of your patient. Your pharmacy must purchase products from a licensed, authorized distributor(s) as permitted by applicable Law. Refer to sections **8.05 Supply of Covered Items; Purchase Invoices** and **8.05.01 Invoice Documents and Records Maintenance** of the Provider Manual.

7. Is my pharmacy liable for lost Covered Items or Covered Items that are not received by Eligible Persons through shipping, mailing, or delivery by common carrier/courier/employee/contractor?

If your pharmacy elects to ship, mail, or deliver Covered Items by common carrier/courier/employee/contractor or other means, it is your pharmacy's responsibility to ensure your selected distribution channel has documented procedures in place to limit potential liability as delivery confirmation may not constitute member receipt of the Covered Item or ensure that timely/appropriate manufacturer handling instructions regarding Covered Items have been met. In the event of an Eligible Person dispute, your pharmacy may be deemed responsible for lost/missing Covered Items or Covered Items not received by the Eligible Person. Notwithstanding the Plan Sponsor's authorization for an emergency override, the Provider retains all liability for the initial Covered Items not received by the Eligible Person. Caremark may reverse claims at its sole discretion. Provider may not seek reimbursement from Eligible Person for non-received Covered Items (refer to section **3.03.06 Limitation on Collection** of the Provider Manual).

8. Do I need to provide Eligible Person educational materials in other languages?

Yes, where required by applicable Law for Eligible Persons. Provider shall provide educational materials in print and telephonic media and have written procedures to have available language interpretation services for any Eligible Person who needs such services including, but not limited to, Eligible Persons with Limited English Proficiency (LEP).

1.06.02 Network Contract Rates/Terms

1. I participate in a Caremark network initiative with performance, clinical, or health care outcome measures. Where can I access my reports?

Caremark provides online access to information on network initiatives that include performance, clinical, or health care outcome measures via the Pharmacy Portal at **rxservices.cvscaremark.com**. Provider may access the Pharmacy Portal to obtain program reports for both Medicare Part D and non-Medicare Part D Plans. Information on how to read and understand your pharmacy's reports is included, among other program-specific information.

2. I am reviewing a Caremark network contract and I don't know if I want to participate. What are various factors I should consider?

It is important for your pharmacy to make a business decision on every network opportunity that is presented to your pharmacy. Your pharmacy should review the terms and conditions as well as the reimbursement rates and only enroll in networks in which your pharmacy agrees the terms and conditions are reasonable and relevant to your business model and the reimbursement rate is acceptable. Consider your pharmacy's business goals and decide if the opportunities align with those of your pharmacy.

1.06.03 Provider Enrollment, Credentialing, Change of Ownership

1. I am a new provider owner. Am I responsible for the liabilities and obligations of the previous owner?

Refer to section **2.06 Change in Ownership** of the Provider Manual.

2. I am selling my pharmacy. Do I have any obligations under the Provider Agreement?

Yes. Refer to section **2.06 Change in Ownership** of the Provider Manual. You also should inform the new owner of any obligations to Caremark that may have been incurred.

3. I am interested in enrolling as a participating Caremark Provider (or I have a new pharmacy I would like to enroll). What steps do I take?

Refer to section **2.02 Steps to Become a Provider** of the Provider Manual.

4. When will I have access to the enrollment information in the Pharmacy Portal? What other information is on the Pharmacy Portal?

Refer to sections **2.02 Steps to Become a Provider** and **1.05 CVS Caremark Pharmacy Portal** of the Provider Manual.

1.06.04 Claims Processing and Benefit Plan Design

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

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

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

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

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

Person code (as printed on the identification card) and patient relationship code data fields are required for submission as outlined in the applicable payer sheet(s). Many times, person code is printed on the identification card. It is important that this information is submitted accurately to Caremark for appropriate drug utilization review (DUR) for that individual to occur.

4. What Banking Identification Number (RXBIN), Processor Control Number (RXPCN), and Group number (RXGRP) do I use for Caremark Eligible Persons?

Provider must request to see the Eligible Person's identification card and examine the identification card to determine what RXBIN, RXPCN, and RXGRP information is available. Provider should submit claims utilizing the corresponding RXBIN, RXPCN, and RXGRP illustrated on the Eligible Person's identification card. Refer to section **3.01.03 Identification Cards** of the Provider Manual.

RXBIN and RXPCN values are also listed in the applicable payer sheet(s) found online at **caremark.com/pharminfo**. If no RXPCN appears on the identification card, submit the default RXPCN according to the RXBIN as outlined in the appendix from the applicable payer sheet(s).

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

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

6. May I waive Eligible Person copays?

Provider must follow the requirements of the Provider Agreement (including the Provider Manual) for collection of Patient Pay Amounts. Typically, promoting or advertising the waiving of copays/Patient Pay Amounts and/or waiving copays/Patient Pay Amounts is strictly prohibited. Refer to sections **3.03 Patient Pay** and **9.09 Denial of Services** of the Provider Manual for full requirement.

7. Can I use a coupon to decrease the Patient Pay Amount?

That depends on the type of coverage the Eligible Person has as well as the product dispensed. Medicare Part D and Medicaid do not allow any coupons to be applied to Covered Items and there could be serious repercussions for Providers who do so. For Commercial coverage refer to section **3.03.03 Coupons and Other Programs** of the Provider Manual for additional information. Also, make sure your state allows for the use of coupons. Provider must disclose all post-adjudication coupon usage. Refer to section **3.03 Patient Pay** for full requirements.

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

Many Plan Sponsors allow for Eligible Persons to secure an early refill for vacation supply. If the Eligible Person states that they are eligible for an early refill for vacation supply, Provider should submit the claim with Submission Clarification Code (SCC) "03". If the Plan Sponsor does allow for an early refill for vacation supply, the refill-too-soon reject will be overridden. If the claim continues to reject, contact the Pharmacy Help Desk for assistance.

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

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

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

Provider must submit the claim through the claim adjudication system to receive the adjudicated response which will include messaging about Plan coverage. The representatives at the Pharmacy Help Desk cannot release Plan limitation information due to the variables that may impact the coverage for a given product.

11. How do I know if the Plan allows coordination of benefits?

Plans may indicate if an Eligible Person's eligibility is supplemental, and Provider may receive a reject indicating that the claim should be submitted to another payer or other COB-related message. For Plan Sponsors that allow coordination of benefits (COB), refer to section **4.10 Coordination of Benefits** of the Provider Manual for additional information regarding COB claim submission.

12. Do I need to bill the specific National Drug Code dispensed?

Yes. Submitted claims information must be accurate and complete. This includes, but is not limited to, billing the actual National Drug Code (NDC) used for each product within a prescription for compound recipe.

13. What data field do I use for the <specific data>?

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

14. If I am a long-term care pharmacy and a long-term care/assisted living facility patient returns home, but I am still dispensing Covered Items and providing clinical care to the patient at home, what codes do I use to submit claims?

If a patient is returned to a non-long-term care/non-assisted living facility residence (at home patient), your pharmacy must submit value "01" for Pharmacy Service Type and value "01" Patient Residence Type. If other values are submitted that indicate the patient is still residing in a long-term care (LTC) or assisted living facility (ALF) when the patient is not residing in an LTC or ALF, your pharmacy may be subject to Chargebacks, non-compliance charges, or other remedies. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual.

For additional claim processing information, refer to the applicable payer sheet(s) found online at:
caremark.com/pharminfo

Note: This document contains references to brand-name prescription products that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Caremark.

2. Credentialing

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

2.01 Provider Credentialing

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

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

- Approval of enrollment, including approval of enrollment with conditions
- Approval of enrollment with limited services (e.g., vaccines, complex compounds)
- Denial of enrollment
- Termination of the Provider Agreement

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

1. Any non-compliance with the terms of the Provider Agreement, serious and/or significant audit findings, or adverse actions by a governmental regulatory or enforcement entity or agency against:
    a. Provider; or
    b. Another provider with any common association, ownership, or relationship to Provider; or
    c. Any of Provider's respective owners (direct or indirect, including passive or other financial investors), officers, directors, Pharmacists-in-Charge/responsible pharmacist, managing employees, employees, or affiliated personnel. This also includes Providers that have billed for other entities or that have billed for claims that were previously found to have migrated from other Providers removed from the network; or
    d. Changes of ownership that are not arms-length transactions.
2. Any conduct that may adversely impact Caremark's relationship with, or Caremark's contractual duties to, a Plan Sponsor.
3. Any conduct that may pose a risk to the health, welfare, safety, or financial well-being of Eligible Persons or the general public.
4. Any other conduct that Caremark, in its sole discretion, determines would adversely affect Provider's ability to fulfill the requirements of the Provider Agreement.
5. If Caremark believes, in its sole discretion, that the Provider may pose an undue risk of potential Fraud, Waste, and/or Abuse.
6. Failure to fulfill any outstanding financial obligations to Caremark and/or Plan Sponsors.

IMPORTANT:

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

2.02 Steps to Become a Provider

1. Review credentialing requirements
2. Complete the "Pharmacy Pre-Enrollment Questionnaire"
3. Create a Pharmacy Portal account to submit enrollment application
4. Complete and submit your application, which includes execution of the Provider Agreement

2.02.01 Review Credentialing Requirements

In order to become and remain a Provider contracted with Caremark, a Provider must meet the definition of a Provider and comply with Caremark's credentialing requirements and obligations contained in Caremark Documents. These obligations are to be fully met during the enrollment process and continue post-enrollment for the duration of Provider's participation in Caremark or Plan Sponsor networks.

Providers must comply with all applicable Laws and provide all Pharmacy Services and Covered Items in a professional manner and in compliance with the highest industry practice standards. Failure to comply may result in remedial action by Caremark including, but not limited to, Provider Agreement termination. These requirements include, but are not limited to, the following:

1. Prior to beginning step two of section **2.02 Steps to Become a Provider** (2. Complete the "Pharmacy Pre-Enrollment Questionnaire"), Provider must:
    a. be open for business and actively operating as a pharmacy in accordance with applicable Law relating to the practice of the pharmacy;
    b. be reachable by mail, telephone, and fax during Provider's hours of operation based on the contact information provided;
    c. have an active NPI and NCPDP Provider ID;
    d. have an active DEA Certificate of Registration and state-controlled substance registration, where applicable; and
    e. have active general and professional liability insurance, including malpractice (see bullet #9 of this section for additional information).
2. Provider must maintain in good standing all federal, state, and local licenses; permits; certifications; and maintain an active NPI and NCPDP Provider ID.
3. Provider must maintain at all times current and valid licensure as issued by the appropriate state agency(ies) in which Provider operates to dispense and, where applicable, into which it ships. Additionally, Provider must meet all standards of operation as described in federal, state, and local laws. Any Pharmacy Services provided during a period where Provider does not possess all required active and valid licenses and/or permits under applicable Law shall be deemed to be invalid and subject to Chargeback.
4. All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist or Dispensing Practitioner (as applicable and according to applicable Law) and in accordance with applicable Prescriber directions and applicable Law.
5. Provider must require and verify that all personnel employed by or contracted with Provider are licensed and qualified to perform their professional duties and that they act only within the scope of their licensure. Provider shall make inquiry and document all past employment associations of all personnel with respect to third-party payor audit history.
6. Notwithstanding anything in the Provider Agreement to the contrary, Provider must comply with all applicable Laws in performing its Pharmacy Services under the Provider Agreement. Refer to section **15.01 Compliance with Laws** of the Provider Manual.
7. Provider must require and verify that Provider and all personnel employed by or contracted with Provider have not been excluded or debarred by any federal or state program. Provider must check the applicable federal and state exclusion lists upon initial hire/contract and on at least a monthly basis thereafter to verify that no employees or contractors are on the list. Provider further agrees that any claim submitted to and paid by Caremark in violation of this section is subject to Chargeback.
8. Provider must require and verify that any individual for whom there has been a restriction, suspension, revocation, probation, or any other disciplinary action taken by a licensing or other oversight agency, does not provide any Pharmacy Services to Caremark or its Eligible Persons. Provider agrees that any claim submitted to and paid by Caremark in violation of this section is subject to Chargeback.
9. Provider must maintain, at its own cost and expense, policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services or failure to perform Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1 million per occurrence and $3,000,000 in aggregate, unless otherwise agreed to by Caremark, or such greater amount as required by Law.
    a. Provider must furnish copies of said policies upon enrolling as a Provider with Caremark and as requested by Caremark thereafter. Failure to maintain the minimum coverage may result in immediate termination.
    b. Provider must notify Caremark immediately in writing if its insurance is canceled, lapsed, or otherwise terminated. Failure to notify Caremark in writing of any such termination of insurance coverage may result in immediate termination.
    c. Provider must notify Caremark of any changes to the policy including, but not limited to, the location schedule.

10. Provider must stock a sufficient amount of drugs and products, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.
11. Provider agrees that Caremark, in its sole discretion, may obtain and use Provider credentialing and recredentialing information from third-party vendors that store Provider's information. This does not relieve Provider of its responsibility to notify Caremark of changes as required by the Provider Agreement.

2.02.02 Complete the "Pharmacy Pre-Enrollment Questionnaire"

To become a participating provider in a Caremark or Plan Sponsor network, Provider must accurately complete and submit the "Pharmacy Pre-Enrollment Questionnaire" to initiate the enrollment process. This includes disclosing information as set forth in "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E) and "Disclosure of Ownership and Control Information" (42 C.F.R. Part 420, Subpart C).

1. Access the "Pharmacy Pre-Enrollment Questionnaire" (under "Forms and Guides") at **caremark.com/pharminfo** and select "Complete pre-enrollment questionnaire".
2. Supply the required information as outlined in the "Pharmacy Pre-Enrollment Questionnaire". It is important for all Providers to complete the form accurately and in its entirety as Caremark relies on this information in making enrollment determinations.
3. Submit the online questionnaire. Upon successful completion of the "Pharmacy Pre-Enrollment Questionnaire" and approval by Caremark, instructions for creating an online Pharmacy Portal account will be sent to the applicant which will include any fees, where permitted by applicable Law (refer to section **2.02.03 Create a Pharmacy Portal Account to Submit Enrollment Application**).

Caremark, in its sole discretion and where permitted by applicable Law, may require additional pre-enrollment credentialing.

2.02.03 Create a Pharmacy Portal Account to Submit Enrollment Application

Applicant must create an online account, in their own name, using the Pharmacy Portal, to complete and submit an online enrollment application. Applicant and Provider must not disclose its Pharmacy Portal account information to a third party, including, but not limited to, enabling a third-party vendor to submit an enrollment application on behalf of the Provider. Applications submitted in violation of this requirement are subject to denial and/or termination of contract. No third-party consultant is permitted to represent Provider nor will Caremark communicate with a third-party consultant unless written consent is provided by Caremark. Provider must provide written documentation describing the business relationship with the third-party consultant upon request.

The online enrollment application must be accompanied by an electronic submission of all required documentation. Failure to submit the online enrollment application with required documentation within thirty (30) days from the date the enrollment application was initiated will result in the expiration of the enrollment application and require the applicant to restart the enrollment application process.

Fee payment:

A fee will apply, where permitted by applicable Law. Payment is due at the time of application submission and is non-refundable. The amount of such fees will be communicated to the pharmacy.

Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. Failure to submit payment, where applicable, within twenty-one (21) days of the date the enrollment application is initiated may result in the denial of the enrollment application and, if applicable, termination of the existing Provider Agreement. The submission of an application and non-refundable fee does not guarantee the application will result in enrollment.

Mail cashier's check or money order to:
CVS Caremark
Attn: Provider Enrollment, MC 129
9501 East Shea Boulevard
Scottsdale, AZ 85260

Submit enrollment questions to Caremark via the "Pharmacy Enrollment Self Service/Pharmacy Provider Question Form" found at **caremark.com/pharminfo**.

2.02.04 Complete and Submit Your Application

Following submission of the online enrollment application, the applicant will be notified in writing by Caremark if any required documentation or information is missing or incomplete. Caremark will contact the applicant by email and telephone call to obtain the missing items. Failure to provide all required enrollment information and documentation

within twenty-one (21) days of the first outreach may result in the denial of the enrollment application and, if applicable, termination of the existing Provider Agreement. Caremark, where permitted by applicable Law, may charge a $75 fee per pharmacy location for each additional request Caremark must make to obtain required documentation and information to complete the enrollment application.

The review of an application will not begin until a complete application is received; the enrollment application is not deemed to be complete until all required documentation including, but not limited to, the attestation to the Provider Agreement by the owner or designated employee with actual authority, are submitted to Caremark. Enrollment applications are reviewed in the order in which they were received. Enrollment decisions are rendered at a point in time with the information available to Caremark at that time. All enrollment decisions will be communicated to applicants in writing.

2.02.05 Additional Application Requirements for Pharmacies Located in a Strike Force Location

If Provider's pharmacy is located in or near a designated strike force location*, in addition to meeting requirements outlined in section **2.02.01 Review Credentialing Requirements**, Provider must:

1. Be open for business and actively operating as a pharmacy in accordance with applicable Law relating to the practice of the pharmacy at the time of application submission, participate in a site visit where applicable, and fulfill enrollment requirements.
2. Agree to an unannounced site visit to inspect the pharmacy before enrollment.
3. Send fee: A fee will apply, where permitted by applicable Law. Payment is due at the time of application submission and is non-refundable. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. The submission of an application and non-refundable fee does not guarantee the application will result in enrollment.

   Mail cashier's checks or money order to:
   CVS Caremark
   Attn: Provider Enrollment, MC 129
   9501 East Shea Boulevard
   Scottsdale, AZ 85260

   *A strike force location may include, but is not limited to, pharmacies located in in an area operated by a Medicare Fraud Strike Force team. Refer to the websites below for additional information.

   - **justice.gov/opa/pr/fact-sheet-health-care-fraud-and-abuse-control-program-protects-conusmers-and-taxpayers**
   - **oig.hhs.gov/fraud/strike-force**
   - **justice.gov/criminal-fraud/health-care-fraud-unit**

2.02.06 Additional Application Requirements for Dispensing Practitioners

In addition to meeting requirements outlined in section **2.02.01 Review Credentialing Requirements**, the Dispensing Practitioner must meet the minimum requirements below:

1. Be open for business and actively operating in accordance with applicable Law relating to the practice of the pharmacy at the time of application submission, participate in a site visit where applicable (see section **2.02.05 Additional Application Requirements for Pharmacies Located in a Strike Force Location**), and fulfill enrollment requirements.
2. Dispense within the Dispensing Practitioner's scope of professional practice. The Dispensing Practitioner will comply with this requirement through computerized edits and purchase of appropriate Covered Items from licensed and authorized distributors/wholesalers/manufacturers.
3. Support Caremark audits. Audits may be conducted in the form of an on-site audit, expanded audit, or desktop audit and require access to the Dispensing Practitioner's records and documents, facility, and practices as Caremark reasonably determines necessary to evaluate Dispensing Practitioner's compliance with the Provider Agreement and applicable Law. Caremark may conduct additional compliance reviews as described in chapter **7. Compliance Reviews** of the Provider Manual.
4. Send fee: A fee will apply, where permitted by applicable Law. Payment is due at the time of application submission and is non-refundable. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. The submission of an application and non-refundable fee does not guarantee the application will result in enrollment.

Mail cashier's checks or money order to:
CVS Caremark
Attn: Provider Enrollment, MC 129
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

2.03 Steps to Become a Complex Compound Provider

Providers are not authorized to submit claims for complex compounds without first obtaining written approval from Caremark and maintaining ongoing compliance with Caremark's requirements. In order to become an approved Provider to submit non-sterile complex compound claims to Caremark and dispense non-sterile complex compounds that are Covered Items to Eligible Persons, Provider must first be currently enrolled with Caremark (refer to section **2.02 Steps to Become a Provider** of the Provider Manual) and accurately complete, in its entirety, the Caremark Compound Application.

Providers wishing to submit claims for complex compounds must:

1. Contact Caremark at **CompoundApplicationTeam@CVSHealth.com**. In the body of the email, include the Provider's name, the corresponding NPI and NCPDP numbers, the contact name, the telephone number, and the request for a Caremark Compound Application.
2. Be currently preparing non-sterile complex compounds and be able to provide a list of top ten non-sterile compounds.
3. Offer a variety of dosage forms.
4. Be in good standing with Caremark.
5. Avoid relationships with any pharmacy staff (including the Pharmacist in-charge), officers, directors, owner(s), and other parties not currently in good standing with Caremark.
6. Complete the Caremark Compound Application and return with all applicable supporting documents to **CompoundApplicationTeam@CVSHealth.com**.
7. Send fee: A fee will apply, where permitted by applicable Law. Payment is due at the time of application submission and is non-refundable. Payment must be submitted to Caremark in the form of a cashier's check or money order made payable to "CVS Health" and mailed to the address below. The submission of an application and non-refundable fee in no way authorizes the Provider to submit complex compounds to Caremark or participate in a Caremark or Plan Sponsor network.

   Mail cashier's check or money order to:
   CVS Caremark
   Attn: Provider Enrollment, MC 129
   9501 East Shea Boulevard
   Scottsdale, AZ 85260

8. Wait for approval letter before submitting complex compound claims.
9. Provider agrees to submit non-sterile complex compounds as described in section **4.07 Multi-Ingredient Compound Processing** of the Provider Manual.

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

2.04 Plan Sponsor Networks

Providers wishing to participate in a Plan Sponsor network may send an email to **RxServices@CVSHealth.com** and provide Provider's name, corresponding NPI and NCPDP number, contact name, telephone number, and the name of the Plan Sponsor network in which participation is requested.

2.05 Notification to Caremark

2.05.01 Notification of Change in Documentation and Other Information

Unless otherwise specified, Provider must notify Caremark in writing within ten (10) business days of any change in Provider's credentials, documentation, and other information provided to Caremark in connection with its most recent enrollment as a Provider, or recredentialing, or to a state board of pharmacy, including, but not limited to, change in credentialing information (e.g., change in "Pharmacy Pre-Enrollment Questionnaire" information, change in enrollment application), name, contact information, email contact address, services, hours of operation, or 24-hour status. Change requests must be submitted through the Pharmacy Change Notification Form, as outlined below, and are not considered final until written confirmation is provided by Caremark. Caremark is required to maintain accurate directories of Providers so that Eligible Persons can quickly find in-network locations to fill their prescriptions. Therefore, in its sole discretion, Caremark may update Provider's credentials without Provider's confirmation using alternative data sources. This does not relieve Provider of its responsibility to notify Caremark of changes as required by the Provider Agreement.

Notwithstanding the foregoing, Provider must notify Caremark of a change in the Provider's physical location prior to the change. Provider is liable to Caremark for any losses that Caremark incurs (e.g., penalties to a Plan Sponsor) based on Provider's failure to comply with this subsection. Provider must be reachable by mail, telephone and fax during Provider's hours of operation based on the contact information provided (and as updated) to Caremark as part of enrollment, credentialing, or recredentialing. If the Provider is unreachable, the Provider may be placed on immediate temporary adjudication suspension.

To notify Caremark of a change, Provider must complete and submit an online "Pharmacy Change Form" found online at **caremark.com/pharminfo**. Scroll to section "Forms and Guides", select "Pharmacy Enrollment Self Service", click on "Go to enrollment self service" and then select "Pharmacy Change Form".

2.05.02 Notification of Closure

Provider must notify Caremark in writing of its or Dispensing Pharmacy's closure no later than ten (10) business days after a closure of its business unless a shorter period is required by Law, a Plan Sponsor, program requirement, or a Caremark Document. Contained within this notification must be the name of the records custodian in the event of future audit-related requests for documentation and information from Caremark or a governmental agency.

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

2.06 Change in Ownership

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

The current Provider, who entered into the Provider Agreement with Caremark, is responsible for notifying Caremark in writing of any change in ownership or control, as defined above, as required by applicable Law, Plan Sponsor or program requirement, or network agreement no later than within ten (10) business days of the change. Failure to notify Caremark may be considered in determining future network eligibility.

The Buyer (defined as any successor in interest to an owner or operator) must notify Caremark in writing of a change in ownership or control, as defined above, no later than ten (10) business days following the change. Changes in pharmacy provider ownership are subject to Caremark's standard pre-enrollment credentialing review process and fee assessment (refer to section **2.02 Steps to Become a Provider** of the Provider Manual). Prior to enrolling with Caremark, Buyer must satisfy all outstanding monetary obligations due to Caremark or Caremark Plan Sponsors, including any pending audit findings, associated with the Pharmacy, Buyer or Seller, or associated individuals. In order to initiate the change in ownership enrollment process, Provider must submit a "Pharmacy Pre-Enrollment Questionnaire" found at **caremark.com/pharminfo.** Click on "Forms and Guides" and select "Pharmacy Pre-Enrollment Questionnaire". Complete your information on page one and then select enroll type of "Change of Ownership" on page two. Upon successful submission of the "Pharmacy Pre-Enrollment Questionnaire", instructions for the creation of an online Pharmacy Portal account will be sent to applicant via email.

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

1. Where the Buyer has no existing relationship with Caremark:
    a. It must execute a new Provider Agreement and meet all of Caremark's credentialing requirements, including completion of the "Pharmacy Pre-Enrollment Questionnaire", in order to initiate the credentialing process for the acquired pharmacy or pharmacies. Refer to section **2.02 Steps to Become a Provider** of the Provider Manual.
    b. Caremark, in its sole discretion, may allow assignment of the Provider Agreement for the acquired pharmacy to the Buyer.
    c. A change of ownership is not effective until a decision is rendered by Caremark and communicated in writing by Caremark.
2. In the event that the Buyer has an ownership interest or operating rights in an existing Provider, Caremark may elect to:
    a. Apply in whole or in part the terms of the acquired pharmacy's Provider Agreement to the acquired pharmacy or pharmacies; or
    b. Apply in whole or in part the terms of the Buyer's Provider Agreement to the acquired pharmacy or pharmacies; or
    c. Require Buyer to complete credentialing and execute a new Provider Agreement for the acquired pharmacies.

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

Current Provider and potential new Provider shall inform Caremark in writing no later than ten (10) business days after the sale or transfer of any prescription file other than individual prescriptions transferred in compliance with Law. Please include the state pharmacy closure form, where applicable.

Completing a Caremark recredentialing survey or notifying a third party, e.g., a PSAO or NCPDP, of a change of ownership does not qualify as meeting the obligation to notify Caremark and completing a change of ownership under the Caremark contract. Buyer is required to follow and complete the entire process described in this section (**2.06 Change of Ownership**) to comply with the Buyer's obligations to Caremark. A change of ownership is not effective until a decision is rendered by Caremark and communicated in writing by Caremark.

Mail change of ownership notification to:
CVS Caremark
Attn: Provider Enrollment, MC 129
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

2.07 Recredentialing

Caremark will periodically recredential Providers as required by contract or Law. When requested, Provider will be required to submit requested information and/or documentation to Caremark in the communicated time period. Failure to supply the information and/or documentation in the requested manner and time period may result in suspension, termination, or other potential remedies.

Completing a Caremark recredentialing survey or updating a third party, e.g., a PSAO or NCPDP, of notifications of change and other information does not relieve Provider of its responsibility to notify Caremark of changes as required by the Provider Agreement. Refer to section **2.05 Notification to Caremark** and **2.06 Change in Ownership** of the Provider Manual for information on how to complete a change in this information.

2.08 Reporting of Investigations and Disciplinary Actions

Provider in writing with specificity must notify Caremark within ten (10) business days if:

1. Any of Provider's licenses or permits that are required under applicable Law for Provider to provide Pharmacy Services is, or is in jeopardy of being, suspended or revoked;
2. There are proceedings related to Pharmacy Services that may lead to an adverse action against Provider or affiliate of Provider, or any of their respective officers, directors, current/former employees, or owners (direct or indirect);
3. Any adverse action is taken against (a) Provider; (b) officer, director, current/former employee, owner (direct and indirect) of Provider or affiliate of Provider including, but not limited to, action taken by a Board of Pharmacy, Office of Inspector General (OIG), System for Award Management (SAM), law enforcement, Drug Enforcement Administration (DEA), or other regulatory body;
4. There is a subpoena of records, issuance of a civil investigative demand letter, plea of no contest, or a filing of a civil lawsuit against a Provider related to Pharmacy Services or Provider's business practices;
5. There is a seizure by law enforcement of Provider's prescription records, computer systems, financial records, accounts, or real property;
6. Provider or affiliate of Provider, or any of their respective officers, directors, Pharmacists-in-Charge/responsible pharmacist, managing employees, employees, or owners (direct and indirect) enters into a settlement agreement, Corporate Integrity Agreement, or consent order with a governmental or regulatory agency relating to Pharmacy Services or Provider's business practices, even if there is no admission of liability; or
7. Provider is terminated from a third-party payer's (including a pharmacy benefit manager) network based on cause.

Provider must notify Caremark in writing to:
CVS Caremark
Attn: Provider Enrollment, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

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

2.09 Criminal Offense Related to Federal Health Care Programs

2.09.01 Pharmacy Criminal Offense

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

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

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

2.09.02 Prescriber Criminal Offense

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

2.10 Federal Health Care Programs Participation Exclusion: Pharmacy

If Provider is excluded or debarred from participation in any federal health care program (as defined in 42 U.S.C. 1320a-7b(f)), Provider must immediately notify Caremark of any such exclusion or debarment. Provider will be immediately terminated from participation in all Caremark networks. Provider shall not submit any claim to Caremark for a prescription dispensed by Provider if Provider is excluded or debarred from participation in any federal health care program.

Provider shall not allow any person (whether as an officer, director, employee, contractor, agent, volunteer, owner, or otherwise) who is excluded or debarred from participation in any federal health care program to directly or indirectly provide any item or service under the Provider Agreement or otherwise in connection with the Pharmacy Services including, without limitation, any administrative or management services. Provider agrees to implement a policy requiring all new and existing persons engaged by Provider (whether as an officer, director, employee, contractor, agent, volunteer, owner, or otherwise) to immediately disclose to Provider any debarment, exclusion, or other event that makes them ineligible to perform work related directly or indirectly to federal health care programs. Upon such disclosure, Provider must immediately reassign such person to work that does not involve or relate, directly or indirectly, to the provision of items or services under the Provider Agreement or otherwise in connection with the Pharmacy Services including, without limitation, any administrative or management services.

Provider hereby certifies that:

1. Provider will review the OIG List of Excluded Individuals/Entities (LEIE) and SAM list prior to engaging any officer, director, employee, contractor, agent, volunteer, owner, or otherwise, and monthly thereafter and upon any change of ownership in order to ensure that Provider does not allow any person who is excluded or debarred from participation in any federal health care program to directly or indirectly provide any item or service under the Provider Agreement or otherwise in connection with the Pharmacy Services including, without limitation, any administrative or management services. Provider will immediately remove any person/entity from employment if found on these lists and must immediately notify Caremark. Provider agrees to provide such additional information or documentation in this regard as Caremark may require.
2. Provider will review the Social Security Administration's Death Master File upon initially hiring or engaging any officer, director, employee, contractor, agent, volunteer, owner, or otherwise, and monthly thereafter and upon any change of ownership in order to prevent fraudulent use of Social Security numbers.

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

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

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

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

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

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

3. Pharmacy Services and Standards

3.01 Providing Pharmacy Services to Eligible Persons

3.01.01 Professional Judgment and Conduct

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

3.01.02 Verification of Eligible Persons

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

3.01.03 Identification Cards

In most cases, the Eligible Person's identification card will be produced in the most current NCPDP format and will contain the Eligible Person's identification number, RXBIN/RXIIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information. Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

An identification card may show the identification number for the Eligible Person only or it may show the identification numbers for the Eligible Person and their dependents.

3.01.04 Nondiscrimination

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

3.01.05 Eligible Person Solicitation

Provider must not directly or indirectly obtain prescriptions for Eligible Persons via (1) obtaining an Eligible Person's primary care provider or billing information through unsolicited methods; and/or (2) contacting or offering to contact a Prescriber on an Eligible Person's behalf without a preexisting relationship with the Eligible Person. Provider shall not obtain a prescription from a Prescriber not expressly requested by the Eligible Person or by suggesting to an Eligible Person that their Prescriber or health plan wants the Eligible Person to receive a Covered Item without the Prescriber's express knowledge and authorization. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives including, but not limited to, adherence initiatives, gaps-in-care management, or comprehensive medication reviews with Eligible Persons, or educating Prescribers with respect to formulary changes or other Plan design changes that may be relevant to the Prescriber's treatment plan for the Eligible Person.

3.01.06 Eligible Person Complaints

Provider must cooperate with Caremark and Plan Sponsors to resolve Eligible Person complaints. Provider must make a reasonable effort to rectify the situation that leads to the Eligible Person complaint. Provider must maintain written records of events and actions surrounding each complaint.

Provider must participate in and comply with a Plan's applicable appeal, grievance, and external review procedures, including Medicaid and Medicare Part D appeals and expedited appeals procedures, and the resulting decisions of the Plan.

Provider must provide to Caremark timely responses for CMS Complaint Tracking Module (CTM), in accordance with CMS-specified response times, which are typically within twenty-four (24) hours of receipt of the grievance. Provider must also provide to Caremark timely responses within three (3) to five (5) business days for all other non-CMS complaints/grievances.

3.01.07 Patient Receipts and Insurance Profiles

Provider may print the Usual and Customary Price and Patient Pay Amount on receipts and insurance profiles provided to an Eligible Person. Provider reimbursement pricing information and prices paid to Provider for individual claims under this Provider Agreement are Confidential Caremark Information and may not be disclosed on patient receipts or insurance profiles, subject to applicable Law. Refer to section **13.03 Confidentiality** of the Provider Manual.

Caremark has the right to review and audit documentation to validate Provider's compliance with this section.

3.01.08 Educational Materials and Efforts

Provider must utilize all educational materials to benefit Eligible Persons. All information contained in educational materials related to products, programs, services, and Plan Sponsor announcements constitute Caremark Documents and are Confidential Caremark Information.

Caremark may educate Provider about products, programs, and services as well as distribute Plan Sponsor announcements. Educational materials may be distributed through various means, including email, fax, mail, or posted on one of the Caremark websites or the Pharmacy Portal. Refer to sections **1.04 Pharmacy Communications** and **1.05 CVS Caremark Pharmacy Portal** of the Provider Manual.

3.02 Dispensing Requirements

3.02.01 Hours of Operation

Provider must maintain hours of operation that meet the needs of the community, but in all circumstances in accordance with applicable Law. Provider must communicate those hours of operation to Caremark upon enrollment and upon any changes. Refer to sections **2.05.01 Notification of Change in Documentation and Other Information** and **2.06 Change in Ownership** of the Provider Manual. Provider must be reachable by telephone or fax during Provider's hours of operation (except as described in section **14.10 Force Majeure** of the Provider Manual).

Provider must maintain, at its own cost and expense, a publicly listed business telephone number for each Dispensing Pharmacy whereby Eligible Persons, Caremark, and the general public will be able to reach Provider and a Licensed Pharmacist during all hours of operation. Provider must also maintain, at its own cost and expense, a dedicated telephone number for fax transmissions to Provider from Caremark and Prescribers that is available around the clock.

If Provider is unreachable after reasonable attempts, Caremark reserves the right to suspend the participation status and other remedies available to Caremark, pending further investigation.

3.02.02 Drug Stock and Inventory

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

3.02.03 Aberrant Practices and Trends

Caremark has implemented programs to address aberrant Provider practices or trends in Caremark retail networks. Providers participating in a Caremark network(s) must not engage in aberrant practices or trends that significantly increase Plan Sponsor or Eligible Person cost without proportional value including, but not limited to:

1. Dispensing aberrant quantities of a Covered Item and/or disparate volume of claims or products within a therapeutic category (e.g., topicals, dermatologicals), as measured by number of claims, quantity dispensed and/or dollars.
2. Demonstrating purchasing practices (e.g., higher cost products) that are not in keeping with the aligned goal of safeguarding both the health and financial welfare of Eligible Persons and Plan Sponsors.
3. Disregarding Eligible Persons' private and confidential identification information by using or misusing member data for Provider's own use (e.g., submitting test claims with no subsequent paid claims – also known as "negative" claims) and/or without Prescriber prescription authorization.
4. Participating in actions, programs and/or business models that result in the selection and dispensing of products that increase the amount billed to Plan Sponsors for Covered Items to Eligible Persons.
5. Engaging in practices that focus on Provider's financial interests rather than providing high quality and cost-effective clinical care for Eligible Persons and Plan Sponsors.

In the event Provider breaches any of the above provisions of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark, including Chargeback of applicable claims, in a manner consistent with all applicable laws.

3.02.04 Dispensing Covered Items to Eligible Person's Agent

Provider must obtain the consent of the Eligible Person in order to dispense a Covered Item to a licensed health care practitioner in a non-custodial setting, except for deliveries to a family member of the Eligible Person when the Eligible Person is not present at the time of the dispensing of the Covered Item.

3.02.05 Performance Initiatives

Provider must support all Caremark performance initiatives that Provider has agreed to or where Provider has failed to opt out according to the terms of the notification as may be communicated by Caremark, including, but not limited to: programs with performance, clinical, or health care outcome measures which may include adherence and drug therapy gap alerts; retrospective safety review alerts; formularies; prior authorization programs; managed drug limitations programs; generic incentive programs; dose optimization programs; step therapy programs (refer to chapter **5. Clinical Programs, Services and Related Messages** of the Provider Manual for a further description of these initiatives) and any criteria in such performance initiatives.

As part of the performance initiatives, Provider must inform Eligible Persons when a non-formulary product has been prescribed and Provider must use best efforts to contact the Prescriber to encourage formulary compliance. Provider may be paid a fee for services related to such performance initiative efforts.

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

3.02.06 Dispensing Errors

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

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

3.03 Patient Pay

3.03.01 Collection of Patient Pay Amounts

Patient Pay Amounts (e.g., copayments, coinsurance) is an extremely important tool to help align the needs of Eligible Persons with those of the Plan Sponsor. The disclosure of the Patient Pay Amount to the Eligible Person is an important step in the adjudication and dispensing process of a Covered Item as it can assist with ensuring the necessity of a specific product. The Eligible Person may choose to find a more cost-effective alternative that is therapeutically equivalent, resulting in cost savings for the Plan Sponsor while maintaining quality patient care. Provider must disclose to each Eligible Person the Patient Pay Amount prior to dispensing the prescription so the Eligible Person has the opportunity to make an informed decision. Provider has the right to provide an Eligible Person with information about the cost of a Covered Item, as well as alternative options that lower cost, to assist the Eligible Person in finding affordable, clinically appropriate care. Any information provided to an Eligible Person concerning the Patient Pay Amount and/or alternative options must be consistent with applicable Law and professional judgment.

Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claim adjudication system and in accordance with section **4.05 Usual and Customary Validation** of the Provider Manual. Provider must keep evidence of the collection of Patient Pay Amount for review.

Provider has the right to provide an Eligible Person with information about the cost and reimbursement amount of their product including lower-cost alternatives to assist the Eligible Person in finding affordable, clinically appropriate, alternative products. Failure to collect Patient Pay Amounts is prima facie evidence of a Fraud, Waste and Abuse (FWA) practice.

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

3.03.02 Usual and Customary Price

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

3.03.03 Coupons and Other Programs

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

Provider must follow specific requirements to use a Pharmaceutical Manufacturer Coupon program to reduce the Patient Pay Amount.

1. Pharmaceutical Manufacturer Coupons may be accepted by Provider and applied to reduce a Patient Pay Amount for a Covered Item only if:
    a. The Provider has complied with all terms and conditions of the Pharmaceutical Manufacturer Coupon program including, but not limited to, program prohibitions on the use of a Pharmaceutical Manufacturer Coupon in connection with Covered Items reimbursed by a governmental health care program; and
    b. The Covered Item is not a compounded product, 510(k) cleared medical device, or Medical Food.
2. In addition, only certain Covered Items may have Pharmaceutical Manufacturer Coupons applied to reduce the amount the Eligible Person is required to pay. The following categories of Covered Items are the only ones where a coupon may be used:
    a. The Covered Item is approved by the U.S. Food and Drug Administration (FDA) through a New Drug Application (NDA) or Abbreviated New Drug Application (ANDA), and is published in the Approved Drug Products with Therapeutic Equivalence Evaluations (or commonly known as the "Orange Book"); or
    b. The Covered Item has a Biologics License Application (BLA), including drugs classified as biosimilars approved under section 351(k) of the Public Health Service Act, and is published in the Lists of Licensed Biological Products (or commonly referred to as the "Purple Book"); or
    c. The Covered Item is an over-the-counter (OTC) Covered Item marketed under an official final OTC monograph.

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

FDA approved products are searchable on the "Orange Book" at the following website which may be updated from time to time:

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

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

fda.gov/drugs/therapeutic-biologics-applications-bla/purple-book-lists-licensed-biological-products-reference-product-exclusivity-and-biosimilarity-or

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

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

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

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

3.03.04 Proof of Payment

Provider must maintain a trackable and verifiable proof of payment by Eligible Person of the Patient Pay Amount [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash including the corresponding prescription numbers, dates of fill and patient paid amount], which shall be subject to Caremark audit and/or compliance review.

Provider must maintain proof of payment of the Patient Pay Amount [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash], by other persons, organizations, foundations, charities, etc., on Eligible Person's behalf, which shall be subject to Caremark audit and/or compliance review.

If the Patient Pay Amount is reduced due to a coordination of benefits (COB), Provider must provide trackable and verifiable evidence that demonstrates the COB claim payment by coupon(s) or other payer(s) including, but not limited to, RXBIN, RXPCN and RXGRP, and the source of internal or external payment documenting the prescription number, dates of fill, and amount, which shall be subject to Caremark audit and/or compliance review.

3.03.05 Excess Collections

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

3.03.06 Limitation on Collection

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

3.03.07 Patient Inducements

Provider may not offer or provide any item of value including, but not limited to, gift cards, coupons, or free goods or services, to an Eligible Person to induce or reward the purchase of Pharmacy Services or Covered Items from Provider, unless such items are nominal in value (meaning a value of $15 or less) and the aggregate value of items given to an Eligible Person does not exceed $75 per year, as documented in Provider's records that are subject to audit. Further, notwithstanding the foregoing, Provider may not offer or provide any inducement to an Eligible Person that is prohibited by any applicable Law. This section does not apply to Pharmaceutical Manufacturer Coupons which are addressed in section **3.03.03 Coupons and Other Programs** of the Provider Manual.

3.03.08 Waivers

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

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

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

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

3.03.09 Financial Hardship Program

Waivers based on an individualized determination of financial need under a financial hardship program must meet the following requirements.

1. The terms of the financial hardship program must be set forth in a formal written policy adopted by Provider. The policy must specify the documentation required to establish financial need, the criteria for determining eligibility for financial hardship relief and the level of relief to be provided, the application review and approval process, and recordkeeping requirements.
2. Eligible Persons seeking relief under the financial hardship program must submit an application and provide reasonable and objective documentation of financial need that includes federal tax returns and other appropriate documentation.

3. The criteria for determining eligibility for financial hardship relief and the level of relief to be provided must be reasonable.
4. Written notice of qualification for financial relief under the financial hardship program must be provided in writing to the Eligible Person. This notice must specify the amount or portion of the Patient Pay Amount that is being waived and the period of the waiver.
5. Eligibility for continued financial relief under the financial hardship program must be reviewed on at least an annual basis. This review shall be based on an updated application and updated supporting documentation provided by the Eligible Person.
6. Records must be maintained for each Eligible Person receiving financial hardship relief under the financial hardship program. The records must include, at a minimum, the application and supporting documentation submitted by the Eligible Person and a copy of the notice of qualification sent to the Eligible Person.
7. Provider personnel providing final financial hardship approval must be employed by Provider and shall not be contractors or agents of Provider. The identity of the personnel granting approval must be documented and provided as requested by Caremark.
8. The financial hardship program may not be advertised or promoted.
9. The financial hardship program may not be funded, in whole or in part, by any third party.
10. The financial hardship program must meet all requirements and restrictions of applicable Law.

3.03.10 Documentation

Provider must maintain documents to demonstrate its compliance with terms of section **3.03 Patient Pay** of the Provider Manual, and Provider agrees that such documentation is subject to Caremark audit.

3.03.11 Violations

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

3.04 Standards of Operation

Participation in Caremark's retail networks is limited to Providers defined in the **Glossary of Terms** in the Provider Manual, that are Dispensing Pharmacies or Dispensing Practitioners that also meet the definition of a "Retail Pharmacy". A "Retail Pharmacy" is defined as either (1) a duly licensed and established community pharmacy that serves walk-in patients and dispenses or dispenses and administers specialty or non-specialty prescription products to patients through in-person hand delivery at the point of sale; or (2) a duly licensed Dispensing Practitioner that serves patients with whom the Dispensing Practitioner has a physician-patient relationship and dispenses or dispenses and administers specialty or non-specialty prescription products to patients through in-person hand delivery at the point of sale. Additionally, a Retail Pharmacy Provider must be accessible to all Caremark Eligible Persons for Pharmacy Services, including, but not limited to, establishing pharmacy-patient relationships with Caremark Eligible Persons and where the Retail Pharmacy Provider is required to offer and, where applicable Law or professional practice standards would require, providing face-to-face clinical consultation with Caremark Eligible Persons. A Dispensing Practitioner is required to offer and provide face-to-face clinical consultation opportunities with Caremark Eligible Persons in person and remain available to counsel Caremark Eligible Persons in person at the Caremark Eligible Person's convenience. For additional information regarding Medicare Part D, refer to chapter **10. Medicare Part D** of the Provider Manual.

Not considered "Retail Pharmacies":

For purposes of this definition, any Provider, whether as a chain, as an individual pharmacy location within a chain, or as an independent pharmacy location:

1. Whose number of claims submitted to Caremark for prescriptions that were delivered to Eligible Persons (including common carriers such as USPS, FedEx, UPS or other delivery service) exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy. Caremark further reserves the right to charge back any improper or excessive payments made to Provider based upon its misrepresentation as a Retail Pharmacy; or
2. Whose number of claims submitted to Caremark for specialty products exceeds twenty percent (20%), or as provided by Law, of the total claims submitted to Caremark, by line of business, or by Plan Sponsor (or account group(s) within the Plan Sponsor), in any month, is not considered a Retail Pharmacy; or

3. Who is owned by a 340B covered entity and/or whose volume of claims filled using 340B Drug Pricing Program acquired or replenished drugs is the basis for any pharmaceutical manufacturer denying pharmaceutical rebates for claims submitted by Provider, is not considered a Retail Pharmacy. All Providers must maintain their NCPDP online provider ID profile services question on 340B (i.e., "Physical Location 340B Status") so that it is accurate and up to date; or
4. Who is not a Dispensing Practitioner and not accessible to all Caremark Eligible Persons.

If Provider has misrepresented itself as a Retail Pharmacy and/or modifies its operations such that it no longer meets the definition of a Retail Pharmacy, in addition to all other rights and remedies available to Caremark, and to the extent permitted by applicable Law, Caremark reserves the right to exclude Provider from any retail network(s) in which the Provider is participating or any new retail network(s) established, or to apply unique terms and conditions to such Provider's participation in any retail network(s) in which the Provider is participating or any new retail network(s) established, for all Plan Sponsors or specific Plan Sponsor(s), or account group(s) within a Plan Sponsor, or any combination of the foregoing, and to terminate Provider from Caremark networks.

3.04.01 Other Standards of Operations

1. Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.
2. Providers who utilize an internet site as a routine business practice in the provision of Pharmacy Services (except for refill requests) must maintain Verified Internet Pharmacy Practice Sites (VIPPS) certification through the National Association of Boards of Pharmacy (NABP) but must also otherwise comply with the terms of this subsection.
3. Provider must maintain a process to identify and detect prescriptions prescribed by, or claims for products or services furnished by, an excluded or debarred Prescriber and prevent those prescriptions and claims for products or services from being submitted to Caremark for adjudication and payment.
4. No third-party pharmacy or marketing consultant is permitted to represent Provider, nor will Caremark communicate with the consultant unless written consent is provided by Caremark. Provider must provide written documentation describing the business relationship with the third-party consultant upon request.

3.05 Records

3.05.01 Documents and Records Maintenance

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

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

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

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

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

3.05.02 Signature Log – Hard Copy or Electronic

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

1. Contains a signature which can be individualized or directly related to each prescription dispensed (e.g., prescription number)
    a. For each claim adjudicated through the claim adjudication system, Provider must obtain the signature of the Eligible Person (or their authorized representative) on a dated third-party signature log to confirm that they have received the Covered Item recorded.

   b. Eligible Persons with Plan Sponsors requiring one hundred percent (100%) copayment at the point of service or who have prescriptions delivered also must sign the third-party signature log.
2. Maintains the date of the receipt of Covered Item by the Eligible Person
3. Maintains the quantity received by the Eligible Person
4. Maintains a disclosure to Eligible Person of insurance billing
5. Retrievable for the purposes of audit

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

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

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

3.05.03 Prescription Information

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

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

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

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

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy, electronic prescription record, physicians order, or Provider systems where it can be readily retrievable. In the case of a long-term care pharmacy's standing order, Provider must maintain written record of the Prescriber's review and continuation of the standing order within one year prior to the fill date, or such shorter period as required by applicable Law.

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

3.06 Referrals

3.06.01 Referral Fees

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

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

3.06.02 Referrals to Non-Retail Participating Providers

Provider must refer Eligible Persons to mail order, specialty, and/or other specified pharmacies for certain Pharmacy Services as appropriate for their Plan benefit design and subject to applicable Law.

4. Claims Submission

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

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

4.01 Payer Sheets and Reject Codes

The Caremark Payer Specification Sheets and NCPDP Version D.Ø payer sheets can be found online at **caremark.com/pharminfo**. Please carefully review the applicable payer sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

Caremark utilizes NCPDP reject codes. Providers can refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online. In addition, Providers can contact their software vendor to learn more about submission reject codes.

4.02 General Claim Submission Policies

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

1. Each claim constitutes a representation by Provider to Caremark that the Pharmacy Services were provided to the Eligible Person and that the information transmitted is correct and complete. Submission of incomplete, false, or fraudulent claims is a willful misrepresentation and intentional misconduct by Provider.
2. Unless required by Law, section **4.10 Coordination of Benefits** of the Provider Manual, or requested by Eligible Person, Provider must not submit claims to any other administrator when documentation confirms Eligible Person's eligibility with Caremark.
3. Unless otherwise permitted by applicable Law, each claim submitted must result from a prescription for a Covered Item that was written by a Prescriber and for which Pharmacy Services for a Covered Item were provided to the Eligible Person for whom the prescription was written.
4. If Provider knows or reasonably should know that a prescription did not result from a legitimate Prescriber/patient relationship, Provider must verify the Prescriber/patient relationship prior to dispensing a Covered Item and maintain a record of such verification.
5. Provider must only submit claims to Caremark for Covered Items requested by an Eligible Person. When providing a Covered Item to an Eligible Person through any means other than the in-person receipt of the Covered Item by the Eligible Person or Eligible Person's designee on Provider's premises, Provider must receive and document Eligible Person's request prior to submitting each claim for (a) a Covered Item pursuant to a new prescription received by Provider from a party other than the Eligible Person and (b) a Covered Item pursuant to an available refill of an existing prescription.
6. Provider must submit all claims for a Covered Item for Pharmacy Services via the Caremark adjudication system to ensure that Plan design, quality, and professional practice standards are met, and that safety and drug utilization review (DUR) are applied.
7. All claims must be submitted online using a current HIPAA-named version of the NCPDP Telecommunication Standard and in compliance with the Provider Agreement, the applicable payer sheet(s), the Provider Manual, and applicable Law. Caremark may require additional information to process a claim.
8. Provider must not take any steps to circumvent Plan design or claim edits. Provider must not modify any claim data fields (e.g., modify quantities or days' supply) to bypass Plan edits or Provider Agreement requirements; and Provider must not use a Submission Clarification Code (SCC) value, prior authorization number, Eligibility Clarification Code value or other data element to inappropriately override a reject.
9. Provider must display all NCPDP messaging to the dispensing pharmacist. It is imperative that Provider review the claim response in its entirety, including all messages (e.g., primary and secondary). This may require viewing additional screens.
10. Any changes to a prescription including, but not limited to, the Covered Item being prescribed or directions for use, must be approved by the Prescriber prior to dispensing. Provider must date and document the Prescriber approval on the prescription hard copy or electronic prescription record.

11. To protect the health and safety of the Eligible Person, Provider must review and act upon DUR messages received from Caremark. Provider must perform an internal DUR on each claim to monitor for safety concerns such as drug-to-drug interactions and drug allergy monitoring. Refer to chapter **5. Clinical Programs, Services and Related Messages** of the Provider Manual.
12. Providers must inform Eligible Persons about the proper storage, dosing, utilization, side effects, potential interactions, and use of the Covered Item dispensed within professional practice guidelines.
13. Provider must submit the precise eleven (11) digit Product Identifier for the Covered Item dispensed as defined by the NCPDP Product Identifiers Standard. Claim submissions utilizing a Product Identifier other than the Product Identifier of the Covered Item dispensed are subject to audit review and Chargeback and are not eligible for reimbursement.

4.03 Other Claim Submission Requirements

1. **Quantity Dispensed and Days' Supply:** Provider must submit the accurate days' supply and quantity on all claims prior to dispensing.
    a. Provider must submit only the quantity indicated on the prescription. Provider must enter the exact metric decimal quantity dispensed (no rounding) on all claim transactions. Provider must submit the quantity based on product description (e.g., kit, volume in milliliters, weight in grams, eaches, number of capsules/tablets) according to the NCPDP Billing Unit Standard. If the quantity is uncertain, Provider must contact the Prescriber to determine the appropriate amount to dispense and notate on the prescription hard copy or electronic prescription record.
    b. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product (e.g., exact metric quantity) and Prescriber instructions.
    c. Provider must not adjust the quantity dispensed to circumvent adjudication edits, reimbursement structure, prior authorization edits, or clinical programs.
    d. If the Prescriber indicates ambiguous direction such as "use as directed" or "as needed," (e.g., a product that may be administered on a sliding scale such as insulin or a topically applied product), the Provider must obtain the dosing schedule, dosing range, area of application, frequency, and any other information necessary or applicable to determine the days' supply for the quantity dispensed. For example, with topical products, the FTU (fingertip-unit) chart is a common reference used to estimate the amount of topical product required based on the area of coverage.
    e. Directions and/or area of application may be obtained from either the Eligible Person or the Prescriber, prior to dispensing, and must be notated on the prescription hard copy or electronic prescription record.
    f. Provider must consider product expiration and manufacturer storage recommendations when calculating days' supply for claim transmission (e.g., oral antibiotic that expires after ten (10) days, remaining product should be discarded).
2. **Strength Dispensed:** The strength of the medication identified on the claim must be an accurate reflection of that which was prescribed or documentation of the unavailability of the prescribed strength will be required. Provider must utilize the strength originally prescribed by the Prescriber or use an available higher strength single dose of the same medication as described in section **5.08 Dose Optimization** of the Provider Manual. Provider must not utilize a lesser strength in an increased quantity without documentation of unavailability of the prescribed strength.
3. **Plan Limitations Exceeded:** Claims submitted to Caremark that exceed Plan limits for the days' supply or quantity dispensed will reject with the message, "Plan Limitations Exceeded". The reject message includes the actual limits such as, "Maximum Days' Supply = 34" or "Quantity Limit = 100". Any claims resubmitted must be entered with the accurate quantity and days' supply; however, if the claim submitted has a quantity which represents the smallest commercially available package size or represents a single course of therapy (e.g., 9 vials of Remicade® as a 56-days' supply) and rejects as stated, it is allowable for Provider to resubmit the claim utilizing that quantity and the maximum days' supply as provided in the reject messaging. Provider maintains responsibility to adhere to appropriate refill intervals based on the quantity dispensed and actual days' supply (based on the prescribed dosing schedule). The Pharmacy Help Desk is available for Provider to request a Plan Limitation Exceeded override; if approved, based on Plan Sponsor parameters, Provider must resubmit the claim with accurate approved quantity and days' supply. Provider must document the details of the override granted by the Pharmacy Help Desk on the prescription hard copy or electronic prescription record. For additional information regarding Medicare Part D Claims, refer to chapter **10. Medicare Part D** of the Provider Manual.
4. **Dosage Form and Package Size:** Provider is obligated to use available dosage form and package size that results in the lowest reimbursement.

5. **Ophthalmic Products:** Eye drops should be calculated using 15 drops/mL, unless a more specific drop per mL or uses/package exists.
6. **Products with Unusual Submission Requirements:** Claims for some products frequently result in incorrect reimbursement. To avoid audit Chargebacks, refer to the pharmacy audit tips posted on the Pharmacy Portal at **rxservices.cvscaremark.com**. Provider will be responsible for monitoring and reviewing pharmacy audit tips on the Pharmacy Portal. Refer to sections **1.04 Pharmacy Communications** and **1.05 CVS Caremark Pharmacy Portal** of the Provider Manual.
7. **Repackaging:** Claims for repackaged, relabeled NDCs submitted to Caremark that result in higher reimbursement than claims for non-repackaged, relabeled NDCs may be subject to recoupment.
8. **Non-Covered Items:** Claims submitted to Caremark in accordance with a Plan Sponsor program to allow limited dispensing of a non-Covered Item (e.g., 3-days' supply approved for a product on prior authorization) may be dispensed with the smallest commercially available package size and submitted using the allowable days' supply.
9. **Federal Health Care Programs Prescriber Participation Exclusion:** Provider must not submit any claim to Caremark for a prescription prescribed by, or item or service furnished by, a Prescriber who is excluded or debarred from participation in Medicare, Medicaid, or other Federal or federally-funded health care programs. Provider must maintain a process to identify and detect prescriptions and claims for items or services furnished by an excluded or debarred Prescriber and prevent those prescriptions and claims for items or services from being submitted to Caremark for adjudication and payment. Provider further agrees that any claim submitted to and paid for by Caremark in violation of this section is subject to Chargeback.
10. **Auto-Ship Refill Programs:** Claims submitted for auto-refill programs must only be for Covered Items used in a maintenance therapy. Refer to section **10.04.05 Auto-Ship Refill Programs** of the Provider Manual.
11. **Fill Date:** The fill date is the date on which the Covered Item is prepared and readied for dispensing to the Eligible Person or, in the case of vaccine administration or other professional service, the date the service was administered/performed. Each prescription claim transmitted must indicate the fill date in the Date of Service field (NCPDP field #401-D1). Billing of claims must not be pre-dated or post-dated. The fill date may also be the date a subsequent payer began coverage following Medicare Part A expiration in a long-term care setting only.
12. **Prescription Not Received; Reversal of Claim:** Covered Items not received by an Eligible Person must be reversed by Provider within fourteen (14) days from the fill date through the claim adjudication system. Provider must ensure that an accepted reversal response is received from the claim adjudication system for each claim where the Covered Item was not received by the Eligible Person in accordance with this section. Upon discovery of a Covered Item not received by an Eligible Person in accordance with this section, Caremark in its sole discretion may reverse the claim. Refer to section **4.15 Electronic Submission, Reversal, and Processing Windows** of the Provider Manual.
13. **Pre-Printed Prescriptions:** Provider must not use pre-printed prescriptions that result in the dispensing of Covered Items that are not the most cost-effective even if they are different salts, bases, release characteristics, or additional drugs in combination.
14. **Test Claims:** Unless otherwise authorized in writing by Caremark, Provider must not submit test claims when a prescription order does not exist (e.g., to determine reimbursement rates or benefit coverage prior to a valid prescription being written for the Eligible Person for the medication that is the subject of the claim).
15. **Vaccine and Non-Vaccine Injectable Administration:** When administering vaccines or non-vaccine injectables, submit 'MA' (for Medication Administration) in the Professional Service Code (NCPDP field #440-E5) of the DUR/PPS Segment along with a positive fee amount in the Incentive Amount Submitted (NCPDP field #438-E3) of the Pricing Segment. Provider's submitted Usual and Customary Price must include the charge to administer the vaccine.
16. **No-Cost Vaccines:** When submitting a claim for a vaccine acquired by the Provider at no cost, Provider must submit $0.00 as the Ingredient Cost Submitted (NCPDP field #409-D9) and a value of "15" in the Basis of Cost Determination (NCPDP field #423-DN), unless otherwise communicated by Caremark. Provider's Usual and Customary Price must not include a charge for the vaccine but may include a charge to administer the vaccine.
17. **Durable Medical Equipment (DME):** Provider must only submit DME claims that are payable under the Plan Sponsor's pharmacy benefit. Provider must submit a valid Product Identifier for the DME. If no Product Identifier exists for a DME, Provider must not submit a claim.

4.04 Dispense as Written Codes

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

To ensure proper payment to Provider and the correct Patient Pay Amount of Eligible Persons, Provider must submit all claims with the appropriate Dispense as Written (DAW) code in accordance with the NCPDP Telecommunication Standard and/or as directed by Caremark. Provider must select from the following codes:

DAW 0—No Product Selection Indicated

- Use DAW 0 when dispensing a generic; that is, when no party (e.g., neither Prescriber, pharmacist, nor Eligible Person) requests the branded version of a multi-source product.
- Use DAW 0 when dispensing a single-source brand product.
- Generic pricing may be applied to claims for multi-source products submitted with DAW 0.

DAW 1—Physician Requested Product Dispensed As Written (Substitution Not Allowed By Prescriber)

- Use DAW 1 only when the Prescriber specifies the branded version of a multi-source product on the prescription hard copy or in the verbally communicated instructions (must be evidenced on the prescription hard copy – original and updated); this documentation must occur prior to Pharmacy Services being rendered.
- Computer systems that default to DAW 1 may result in discrepancies and Chargebacks.
- Prescription must follow all applicable Law concerning substitution, including substitution prohibition.

DAW 2—Substitution Allowed—Patient Requested Product Dispensed

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

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed

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

DAW 4—Substitution Allowed—Generic Not In Stock

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

DAW 5—Substitution Allowed—Brand Dispensed As Generic

- Use DAW 5 when dispensing a branded version of a multi-source product as a generic.
- Generic pricing may be applied to claims with DAW 5.

DAW 6—This Value Is Used As Communicated By Caremark

DAW 7—Substitution Not Allowed—Brand Mandated By Law

- Use DAW 7 when prevailing Law prohibits generic substitution for a brand product even though generic versions of the product may be available in the marketplace.

DAW 8—Substitution Allowed—Generic Not Available In Marketplace

- Use DAW 8 when generic substitution is permitted and the brand product is dispensed because the generic is not currently manufactured, distributed, or is unavailable in the marketplace.
- Generic pricing may be applied to claims with DAW 8.

DAW 9—Substitution Allowed By Prescriber But Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed

- Use DAW 9 when the Prescriber has indicated, in a manner specified by prevailing Law, that generic substitution is permitted, but the Plan Sponsor's formulary requests the brand product. Claims submitted with DAW 9 may be rejected if the brand product is not requested by the Plan.

4.05 Usual and Customary Validation

Provider is required to submit accurate Usual and Customary Prices for all claims, including Usual and Customary Prices which are part of a standard set price generic program offered by Provider (i.e., program that is open and requires no enrollment). Upon request, Provider must submit a record of each transaction involving a cash paying customer where, on the same fill date, an identical product was also dispensed to an Eligible Person. Provider may redact confidential patient health information from the record in accordance with applicable Law, but the record must contain the patient charge amount. Caremark has the right to review and audit documentation and records as detailed in this section to validate that Provider's submitted Usual and Customary Price is in accordance with the Provider Agreement.

Provider must not modify its submitted "Usual and Customary Charge", submitted "Gross Amount Due" (as defined by current NCPDP standards), or "Ingredient Cost Submitted" (as defined by current NCPDP standards) on individual claims to bypass Plan edits or Provider Agreement requirements.

4.06 Over-the-Counter Products

Caremark requires a prescription for over-the-counter (OTC) products submitted for reimbursement, except in OTC programs as stated below, and Provider must label and dispense the OTC product in accordance with the prescription and applicable Law. All OTC Covered Items dispensed pursuant to a prescription that are provided to an Eligible Person as prescribed by a Prescriber must be labeled for the Eligible Person. The requirements in chapters **7. Compliance Reviews, 8. Professional Audits** and section **4.13 Prescriber Identification; Prescriptive Authority** of the Provider Manual are applicable to all OTC claims.

Some Plan Sponsors elect to offer a program where Covered Items include certain OTC products to be dispensed without a prescription. These programs may incorporate a monthly or quarterly maximum; in which case, in the event Eligible Persons reach the allowed maximum amount covered by the Plan, per time period, Eligible Persons are responsible for any amount over the allowed maximum including cusp claims and claims submitted after the allowed maximum is exhausted for that time period.

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

4.07 Multi-Ingredient Compound Processing

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

1. All compounds must be submitted online in accordance with the most current applicable payer sheet(s), found online at **caremark.com/pharminfo**.
2. Provider must submit the accurate dosage form of the final compounded product dispensed in the Compound Dosage Form Description Code (NCPDP field #450-EF) in the Compound Segment.
3. Enter the total quantity of the final product dispensed in Quantity Dispensed (NCPDP field #442-E7) in the Claim Segment.
4. Enter the calculated cost of the complete compound as the Ingredient Cost Submitted (NCPDP field #409-D9). This calculated total cost should be no greater than the combined Average Wholesale Price (AWP) cost of all ingredients plus nominal professional allowance based on the Level of Effort (LOE). Caremark, at its sole discretion, will have final determination of professional allowance attributed to claim above the cost.
5. Calculated cost shall not include cost of product associated with waste. Provider must review claims submission to ensure that the quantity submitted is accurate on all claims based on the specificity of the product and Prescriber instructions.
6. Enter the actual Product Identifier (e.g., NDC or UPC) in the Product/Service ID (NCPDP field #407-D7) of each active and inactive product used in the preparation of the compound in the Compound Segment, including any consumable product (e.g., capsule). Each applicable Product Identifier must be entered accurately. Incorrect submission of any ingredient(s) may result in Chargeback of the entire claim.
7. Submit the actual Product Identifier (e.g., NDC or UPC) of each Covered/non-Covered Item. For any products in the compound, such products are only reimbursable if Provider provides, upon Caremark's request, evidence that each of the active and inactive products in the compound is used for an indication that is supported by at least one study from compendia listings of IIb, B or higher to support the utilization of the compound formula. Failure to provide a study in accordance with this section may subject claims to Chargeback.

8. For compounds that require a delivery device as a component of the final product, the device must be submitted as an item in the compound only when the device has a Product Identifier and can be documented as an item; separate devices (e.g., nebulizer) are not reimbursable as a component of the compound.
9. When required, submit the accurate Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) value for the final compounded product in the Route of Administration (NCPDP field #995-E2) in the Claim Segment.
10. Enter the applicable value in DUR/PPS Level of Effort (NCPDP field #474-8E) in the DUR/PPS Segment. The LOE value must reflect the compound types which are referenced in **Figure 1 – Level of Effort Table**, unless otherwise communicated by Caremark. Provider must not program one code for all compounds.

Figure 1 – Level of Effort Table

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

*Using bulk (powder) APIs

11. Coverage determination is performed separately for every item in the compound.
12. Provider may receive a rejected response for a compound claim when item(s) within the compound are not reimbursable; Caremark accepts SCC "08" (Process Compound for Approved Ingredients) which will result in an adjudicated response on all Covered Items.
13. Non-Covered Item(s) within a compound are not reimbursable.
14. Compounds may be a covered Part D drug for Medicare Part D Enrollees provided the compound contains at least one covered Part D drug. The item cost must only include components which satisfy the definition of a covered Part D drug as defined in 42 C.F.R. § 423.100. Components that are not covered Part D drugs as defined by the Centers for Medicare & Medicaid Services (CMS) may be included in the creation of the product, but may not be included in the calculation of the item cost submitted (e.g., sterile water, compounding bulk powders, vitamins, components not utilized for a diagnosis recognized in the compendia). Provider must, however, include all items used in the creation of the compounded product on the multi-ingredient claim transmission.
15. If compounded claims reject for pricing edits (e.g., exceeds maximum cost for the Plan), Provider must not alter the quantity or identity of the individual components submitted to inappropriately enable reimbursement. Provider must not alter the quantity of, or omit an item dispensed, to circumvent Caremark's reimbursement structure, such as providing only 83 days of a 90-day supply prescription or dispensing monthly but billing weekly.

16. Provider must not manipulate claims pricing or the compound indicator for inappropriate financial gain or cause a claim to inappropriately pay.
17. The Caremark adjudicated claim response indicates the total payment for the compound claim. Provider must not balance bill an Eligible Person if prohibited by applicable Law.
18. When a compounded product is dispensed to an Eligible Person, Provider must bill Caremark a single claim for the final compounded product using multi-ingredient functionality (including all active and inactive items used in the creation of the compounded product) and must not bill separate claims to Caremark for individual items or ingredients used in the creation of the compounded product. To protect the integrity of the final product and to control the compounding environment for the safety of the Eligible Person, Provider must compound and dispense the final compounded product to the Eligible Person and must not dispense the individual components or ingredients of a compounded product to an Eligible Person.
19. Compounds that have a commercially available product are not reimbursable.
    a. In the event a commercially available product becomes unavailable (e.g., product is on backorder, product shortage), Provider may choose to compound this item as long as the sum of all items billed does not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount of the commercially available item. Once the product is commercially available, the compounding of this product must cease. Evidence of product shortage or backorder must be maintained for audit purposes.
    b. If there is a commercially available product on the market the use of a bulk chemical(s), crushed tablets, and/or opening capsules to use contents is prohibited unless clinically required (e.g., allergy to inactive ingredient, dietary restrictions). If clinical justification exists, the justification must be documented on the prescription from the Prescriber and, for the compounded product, the sum of the items billed must not exceed the contracted payable amount for the commercially available product or, if the sum of the items exceeds the commercial product contracted amount, Caremark will pay up to the contracted amount.
20. Provider must maintain quality compounding practices in accordance with applicable Law and standards of practice.
21. Compounding must be performed by a qualified person as defined by applicable Law.
22. Outsourcing any portion of Pharmacy Services for compounded products not approved in advance and in writing by Caremark is prohibited.
23. Refer to section **7.03 Additional Information Regarding Compliance Reviews** of the Provider Manual for documentation requirements.

The following must not be billed as a multi-ingredient compound:

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

4.08 Overrides

Caremark has developed general prior authorization numbers for some Plan Sponsors for claims that reject. A Pharmacy Help Desk representative can provide information if the Plan Sponsor allows for an override to allow the claim to adjudicate. In addition, some Medicaid Plan Sponsors provide temporary coverage of non-formulary products. If this is the case, the claim may reject with a message that includes the temporary days' supply that will be covered and the value to enter in the Prior Authorization Number Submitted field (NCPDP field #462-EV) for the claim to adjudicate. Provider must calculate the appropriate quantity for a Covered Item accordingly to correspond with prescription instructions and temporary days' supply. Provider must maintain documentation to substantiate any overrides applied to a claim.

Refer to section **1.03.01 Pharmacy Help Desk** of the Provider Manual for contact information.

4.09 Natural Disasters

Caremark is dedicated to assisting Providers and Eligible Persons in response to emergencies resulting from natural disasters, severe weather, government declared states of emergency, etc., where medical records are either destroyed or not accessible. In the event of an applicable federal or state executive (or other appropriate federal or state governmental agency) emergency declaration, Caremark, consistent with the scope of the declaration, may allow the Provider to submit a specific SCC value to override the refill-too-soon edit for Eligible Persons impacted within the disaster area, e.g., a value of "13", in the SCC field (NCPDP field #420-DK), and the displaced Eligible Person's impacted ZIP Code (do not enter the ZIP Code in which the Eligible Person is temporarily residing as a result of the disaster) in the Patient ZIP/Postal Code field (NCPDP field #325-CP); this will allow an override without requiring a call to the Pharmacy Help Desk. On the prescription hard copy or electronic prescription record, document the specific declared disaster (e.g., tornado, flood, wildfire), how the member was impacted (e.g., medication damaged, temporary relocation) and the date the disaster override was utilized. Permission may vary by Plan Sponsor. If you need assistance, call the Pharmacy Help Desk.

Refer to section **1.03.01 Pharmacy Help Desk** of the Provider Manual for contact information.

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

4.10 Coordination of Benefits

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

Provider must not engage in COB activities with discount programs when prohibited by Caremark or applicable Law. Unless approved in advance and in writing by Caremark, Provider may not submit COB claims to Caremark where a discount program, coupon, or other non-insurance payer type is included as a prior payor in the COB Segment.

Claim submissions with incorrect COB values are subject to Chargeback.

4.10.01 Multiple Transaction Coordination of Benefits

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

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

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

Refer to chapter **10. Medicare Part D** of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**. Please carefully review the applicable payer sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

4.10.02 Single Transaction Coordination of Benefits

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

Refer to chapter **10. Medicare Part D** of the Provider Manual for additional instructions regarding COB with Medicare Part D. Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**. Please carefully review the applicable payer sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

4.11 Long-Term Care Billing

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

For Providers providing home health care or long-term care (LTC) Covered Items to Eligible Persons, each Product Identifier of the individual Covered Item dispensed must be billed only once to Caremark during any 30-day period unless authorized by the Plan Sponsor. Provider must credit Caremark for any unused Covered Items in accordance with the claim adjustment process and all applicable Laws. Provider must submit claims to Caremark's claim adjudication system for LTC Pharmacy Services.

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

4.12 Dispensing Pharmacy NPI/NCPDP

Provider must only submit claims for Pharmacy Services it intends to perform and, at the time of submission, is authorized by the Eligible Person and applicable Law to perform such Pharmacy Services. Submitted claims must include the NPI that is linked to the NCPDP Provider ID (as provided to Caremark) of the Dispensing Pharmacy, defined as the pharmacy that gives or delivers the Covered Item to the Eligible Person. In the event Provider engages with another entity for claim submissions, Provider must notify Caremark. Provider must ensure that any entity using its NPI number, NCPDP number, Software Vendor/Certification ID (NCPDP field #110-AK), or other identifier to submit a claim (including a test claim) to Caremark is acting as Provider's agent and complies with applicable state and federal laws, including, but not limited to, all laws regarding patient privacy and the safeguarding of patient information.

Provider is permitted to utilize a switch that has established connectivity directly with Caremark to facilitate the transport of the claims it submits to Caremark and the responses Caremark provides.

4.13 Prescriber Identification; Prescriptive Authority

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

4.14 Transaction Fees

To the extent permitted by applicable Law, Caremark charges network Providers, and Provider agrees to pay, transaction fees that represent pharmacy network management services Caremark provides to network Providers. For every single transaction Provider transmits to Caremark, Caremark may deduct such amounts for the transaction fee from amounts

payable to Provider. A single transaction is defined as each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claim adjudication system. Each transaction within a multi-claim transmission will be subject to individual transaction fees.

For transaction fees for transactions associated with Medicare Part D claims, refer to section **10.05.16 Medicare Part D Transaction Fees** of the Provider Manual.

4.15 Electronic Submission, Reversal, and Processing Windows

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

All prescriptions not received by an Eligible Person must be returned to stock and claim must be reversed within fourteen (14) days from original submission through the electronic claim adjudication system using data elements as defined by Caremark's payer sheets (found online at **caremark.com/pharminfo**) or as directed by Caremark.

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

Except as otherwise required by applicable Law, or in the event of an urgent need to provide service to an Eligible Person while the claim adjudication system is unavailable (refer to section **4.17 Schedule of Claim Adjudication Systems Maintenance** of the Provider Manual), Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (e.g., cartridge, CD-ROM, tape, batch, or paper) unless prior written approval is received from Caremark or Plan Sponsor.

4.15.01 Universal Claim Form Requirement

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

4.16 Software Certification

Provider must utilize software certified by Caremark and adhere to the NCPDP standards in compliance with HIPAA. Provider must support NCPDP updates as requested from time to time by Caremark. Provider is responsible for and assumes all risk arising from or related to Provider's selection and use of its software. Provider, where not precluded by applicable Law, must indemnify Caremark and its affiliates from and against any claim, cause of action, liability, loss, damage, cost, fines, charges, and/or expenses arising from or related to Provider's selection and use of its software.

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

Provider must submit all claims with the Software/Vendor Certification ID (NCPDP field #110-AK). Each certification ID is assigned by Caremark to a unique vendor and/or software product. Provider must not release their certification ID to be used by any other entity, nor can a Provider use a certification ID to submit a transaction from a system other than the vendor and/or software product associated with the certification ID submitted. Any violation of this rule may result in rejection of the transaction as well as assessment of an Administration Fee. Refer to chapter **7. Compliance Reviews** of the Provider Manual.

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

Refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online.

4.17 Schedule of Claim Adjudication Systems Maintenance

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

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

From time to time, unscheduled system maintenance or other circumstances may occur when the claim adjudication system may not be available to adjudicate claims for a limited time. At any time, a Provider may contact the Pharmacy Help Desk for assistance or information regarding any claim processing related question. Pharmacy Help Desk Representatives are available 24 hours a day, 7 days a week. Refer to section **1.03.01 Pharmacy Help Desk** of the Provider Manual.

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

4.17.01 Additional Required Procedures

1. If the claim adjudication system indicates a host processing error or unexpected reject has occurred, Provider should attempt to resubmit within a few minutes. If the status continues to indicate a host processing error (downtime circumstance), Provider should hold the transaction and attempt to process it again within the next two (2) hours.

   If two (2) hours have elapsed and the same host processing error or unexpected reject continues to occur, call the Pharmacy Help Desk for additional information regarding system availability and other assistance that may be available at that time. The Pharmacy Help Desk is equipped to assist in guiding the pharmacy through the claim resubmission process when the system becomes available.

2. To ensure that each Eligible Person receives their Covered Items, Provider must make reasonable attempts to obtain information necessary to fill a script.

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

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

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

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

Refer to section **1.03.01 Pharmacy Help Desk** of the Provider Manual.

In the event of a downtime outage where Caremark is unable to adjudicate claims, Provider authorizes Caremark to contact Provider's third-party claim transmission technology vendor on Provider's behalf to retrieve claims submitted to Caremark via their third-party claim transmission technology vendor for the purpose of determining claims submitted by Provider but not processed by Caremark. Consistent with section **6.06.02 Disputed Claims, Collected Fees, Amounts, or Recoupments** of the Provider Manual, Provider is obligated to review its Remittance Advice to ascertain whether all claims submitted by Provider during the downtime outage have been processed.

4.18 Provider Taxes

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

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

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

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

In no event does this section give Provider any additional rights than those allowed by Law.

5. Clinical Programs, Services and Related Messages

Provider must support all clinical programs and services and utilize software that will display all messages related to clinical programs and services and that provide for the recording of Eligible Person drug and medical information where utilized by Caremark and as allowed by applicable Law. Provider is required to uphold the same clinical standards of professional judgment relating to and including, but not limited to, seeking cost-effective clinical solutions that benefit the Eligible Person and Plan Sponsor in terms of health and financial welfare of both and refrain from participating in programs that are designed to increase either the Eligible Person or Plan Sponsor's drug spend.

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

5.01 Drug Utilization Review

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

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

The functions of the DUR program are to:

- Analyze prescriptions submitted through Caremark
- Screen prescriptions for several types of therapeutic drug problems
- Provide clinical information related to the claim

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

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

5.02 Drug Utilization Review Conflict Codes and Messaging

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

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

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

5.03 Refill-Too-Soon or Excessive Utilization Reject

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

Examples of extenuating circumstances include:

- Vacation supplies (SCC 03)
- Lost or stolen prescriptions (SCC 04)
- Damaged prescriptions, dropped or broken prescription bottle containing liquid (SCC 04)
- Increase in dosing/therapy change (SCC 05)
- Circumstances such as natural disasters (refer to section **4.09 Natural Disasters** of the Provider Manual)
- Extra supply for school or similar circumstances (e.g., rescue inhalers or epinephrine auto-injectors)

5.04 Drug-Drug Interaction Reject Program

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

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

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

1. **PPS Code REQD: <<Reject Message>>**

   In this case, Provider may resubmit the claim with the indicated Professional Pharmacy Services (PPS) code to override the reject, based on the professional judgment of Provider and in consultation with the Prescriber.

2. **PA REQD: <<Reject Message>>**

   A secondary message will include the PA contact number

   In this case, a prior authorization (PA) is required to override the reject. The message will provide further instructions on how to obtain an override.

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

5.05 Formularies

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

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

When a claim is submitted for a non-formulary drug and the Plan has a closed formulary, it may reject with the following or similar message, which may include a customized drug alternative:

Product Not on Formulary

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

Non-Formulary. Use <<XXX>>

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

5.06 Prior Authorization

In the event Provider breaches this provision of the Provider Manual, Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark, including Chargeback of applicable claims.

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

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

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

PRIOR AUTHORIZATION REQUIRED

MD Call <<XXX-XXX-XXXX>>

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

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

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

Fax: 1-800-408-2386

Phone: 1-800-414-2386

(Hours: Monday through Friday, 8 a.m. to 6 p.m. CT)

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

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

5.07 Managed Drug Limitations/Quantity vs. Time

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

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

PLAN LIMITS EXCEEDED <<# of quantity left>>* or
MAX QUANTITY <<XX PER XX DAYS>>

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

*If prescribed quantity exceeds the Plan parameters, call the Pharmacy Help Desk to verify if prior authorization is available.

5.08 Dose Optimization

Dose optimization is a point-of-service claim reject for selected drugs where multiple daily doses of the drug are prescribed and where a higher strength single daily dose is available and clinically appropriate (e.g., Lipitor® 10 mg 2 tabs/day could be optimized to Lipitor 20 mg 1 tab/day).

For a drug subject to dose optimization, the claim will reject with the following or similar message:

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

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

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

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

5.09 Step Therapy

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

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

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

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

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

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

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

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

5.10 Plan Sponsor Programs

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

5.11 Federal Regulatory Quality Assurance Programs

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

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

5.12 Clinical Studies/Trials

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

Provider requests for approval must include all of the following details:

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

Requests for approval can be sent to the following address:

CVS Caremark
Attn: Pharmacy IRB Study Review, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

The requirements of this **Clinical Studies/Trials** section do not apply to FDA-approved clinical trials.

5.13 Vaccines and Medication Administration

1. Plan Sponsors may include coverage for the administration of vaccines, non-vaccine injectable products, or other Covered Items as part of a Plan. Provider is required to comply with applicable Law when administering a Covered Item. Provider is required to:
    a. Train all personnel and comply with all applicable storage, dispensing, and administration requirements for dispensing and administration of Covered Items as normally implemented by members of their health care profession in good standing in the community.
    b. Comply with the requirements of the Vaccine Injury Compensation Program (VICP) or other compensation program, where applicable, when administering vaccines.
    c. Implement a system capable of reporting the administration to a state or governmental immunization reporting registry, the Eligible Person's primary care provider (or Prescriber), and public health agencies.
    d. Provide Eligible Persons with a written or electronic record of the Covered Item's administration and, where applicable, with any documentation provided by the manufacturer intended for patient use [e.g., vaccine information statement (VIS) or a state or governmental immunization registry].
    e. Report vaccine administration errors and adverse events to the Vaccine Adverse Event Reporting System (VAERS) and to any revised safety reporting requirements as required.
2. When administering a Covered Item that requires multiple doses, including a maintenance dose, Provider must monitor the interval between administered doses for clinical appropriateness. Accordingly, Provider must:
    a. Maintain an accurate accounting of the number of doses that the Eligible Person has received from Provider and the date administered. If Eligible Person has received a previous dose from another provider, Provider must make reasonable efforts to document when Eligible Person has received a previous dose, which may include the use of a vaccine registry or other accessible records, or verbal information provided by the Eligible Person, Prescriber, or prior provider.
    b. Implement and utilize a program that encourages the Eligible Person to receive subsequent doses of a Covered Item when necessary, including a multiple dose vaccine, within the expected timeframe outlined in the FDA approval, Emergency Use Authorization (EUA), or as prescribed. Provider agrees to provide a copy of the Policy and Procedure or Work Instructions regarding tracking of multiple doses, their administration date, and the program to encourage Eligible Person compliance when requested by Caremark.

6. Network Participation and Payment

6.01 Network Participation

Caremark may offer Provider the opportunity to participate in one or more Caremark or Plan Sponsor-specific networks from time to time via a network enrollment form, network addendum or other Caremark Document. Provider should review the network's participation terms carefully, which may include network-specific reimbursement.

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

Notwithstanding anything to the contrary in the Provider Agreement and absent applicable Law to the contrary, by participating in a Caremark network, Provider agrees to provide Pharmacy Services for Covered Items to all Eligible Persons for each Plan Sponsor utilizing the network and as in accordance with the Provider Agreement unless professional judgment dictates otherwise; provided that Caremark, or Caremark on behalf of a Plan Sponsor, reserves the right to limit Provider's participation in a network to certain Plan Sponsors based upon Plan Sponsor network design.

Plan Sponsors may make determinations about Provider network participation.

6.02 Provider Payment

Caremark will reimburse Providers for Pharmacy Services for Covered Items provided as set forth in the Provider Agreement, including any amendments, network enrollment forms, exhibits, and this Provider Manual. Even if Provider has not signed a rate schedule, Provider is deemed to have accepted reimbursement and participation terms, including the finalization of any applicable post-adjudication settlement, in the Caremark or Plan Sponsor network in which Provider submits and Caremark does not reject the claim for an Eligible Person in that network, in accordance with applicable Law.

Notwithstanding any other provision in the Provider Agreement, in the event of a conflict between the reimbursement rate indicated through the claim adjudication system and a network enrollment form or addendum or any other agreement, the claim adjudication system reimbursement rate will apply provided there is no error in the claim adjudication system resulting in overpayment to Provider or to Eligible Person. In addition, any post-adjudication settlements applicable to the claim or network will apply.

6.02.01 General Reimbursement

The applicable Price Type(s), percentage added to or subtracted from the Price Type, Dispensing Fee(s), and other reimbursement terms will be set forth in a network enrollment form, network addendum, or transmitted online via the claim adjudication system.

Notwithstanding any other provision in the Provider Agreement, claims submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network may be reimbursed at the lower of the following less the applicable Patient Pay Amount:

- Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee (or if applicable Price Type is unavailable for a given product, Caremark will pay Provider based upon an alternate Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type plus the applicable Dispensing Fee); or
- Maximum Allowable Cost (MAC) plus the applicable Dispensing Fee; or
- Ingredient cost submitted by Provider plus the applicable Dispensing Fee; or
- Provider's Usual and Customary Price; or
- Provider's submitted "gross amount due" (as defined by NCPDP); or
- For worker's compensation claims, the reimbursement amount prescribed by applicable Law; or
- The Medicare Drug Price Negotiation Maximum Fair Price plus the applicable Dispensing Fee less the applicable Patient Pay Amount, if applicable to an MFP-eligible individual; or
- For Coordination of Benefit (COB) claims, Provider's submitted Other Payer Patient Responsibility Amount(s).

6.02.02 Multi-Ingredient Compound Reimbursement

Multi-Ingredient compound products submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of the following less the applicable Patient Pay Amount:

- The applicable Dispensing Fee plus the applicable amount based on the level of effort*, if submitted, plus for each ingredient that is a Covered Item, the lesser of (1) applicable Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type (2) MAC or (3) compound ingredient cost submitted; or

- Ingredient cost submitted plus the applicable Dispensing Fee plus the applicable amount based on the level of effort, if submitted (provided Provider accurately submits the ingredient cost submitted in accordance with the Provider Manual); or
- Provider's Usual and Customary Price; or
- Plan Sponsor-specific reimbursement; or
- Provider's submitted "gross amount due" (as defined by NCPDP); or
- For worker's compensation claims, the reimbursement amount prescribed by applicable Law.

*Refer to "Figure 1 – Level of Effort Table" in section **4.07 Multi-Ingredient Compound Processing** of the Provider Manual.

6.02.03 Vaccine and Non-Vaccine Injectable Administration Reimbursement

Covered vaccines and non-vaccine injectable products dispensed and administered to Eligible Person submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of the following less any applicable Patient Pay Amount:

- Price Type plus the applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee, plus applicable Administration Fee (or if the applicable Price Type is unavailable for a given Covered Item, Caremark will pay Provider based upon an alternate Price Type plus applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee, plus the applicable Administration Fee); or
- MAC, plus the applicable Dispensing Fee, plus the applicable Administration Fee; or
- Applicable reimbursement amount for the Covered Item, dispensing and administration described in a network enrollment form, network addendum, or transmitted online via the claim adjudication system; or
- Ingredient cost submitted by Provider, plus the applicable Dispensing Fee, plus the applicable Administration Fee; or
- Provider's Usual and Customary Price; or
- Provider's submitted "gross amount due" (as defined by NCPDP).

6.02.04 Adjustments to Reimbursement

All calculated reimbursement to Provider may be adjusted by any of the following:

- Applicable Patient Pay Amount
- Applicable Provider taxes
- Incentive amount(s) paid
- Other amount(s) paid (e.g., delivery fee)
- For COB claims, by all applicable other payer(s) amounts paid
- For consumer card networks, by the applicable consumer card administration fee

Unless otherwise required by a Plan Sponsor, including a consumer card Plan Sponsor, Caremark may increase one or more components of the calculated reimbursement above to cause a zero-balance due (in lieu of a negative-balance due) once the applicable Patient Pay Amount is subtracted.

6.02.05 Post-Adjudication Settlements

Many Caremark and Plan Sponsor networks include additional financial terms that will be calculated and settled between Caremark and Provider post-adjudication, subject to applicable Law. The terms of any post-adjudication settlement will be set forth in a network enrollment form, network addendum, or other Caremark Document. Post adjudication settlements include, but are not limited to:

- Performance Payments
- Network processing fees
- Supplemental dispensing fee payments
- Effective rate reconciliation
- Other fees

Where a post-adjudication settlement is applicable to a Caremark or Plan Sponsor network, Provider's consideration for participation in such network includes the post-adjudication settlement. Accordingly, Provider's acceptance of reimbursement for a claim processed for a network where a post-adjudication settlement applies obligates Provider to finalize the post-adjudication settlement.

6.02.06 Other Entity Adjudication

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

6.03 Changes to Average Wholesale Price

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

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

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

6.04 Maximum Allowable Cost

Maximum Allowable Cost (MAC) is a commonly used tool to control costs by establishing a fair but competitive unit price generally at a product level, regardless of supplier. MAC pricing incents pharmacies to buy generic products in the most cost-effective manner, including volume discounts, in order to keep overall prices down for Eligible Persons and Plan Sponsors. Because Caremark does not have visibility into pharmacy wholesaler arrangements or what is paid for a product, market pricing data is used to determine a feasible acquisition cost that is then used to set a floor for MAC prices to help ensure the reimbursement minimally covers, and is often higher than, the estimated acquisition cost of the drugs dispensed. Caremark estimates acquisition cost using aggregate information from wholesalers along with third-party sources, including application of a discount to account for purchasing rebates and volume discounts. MAC prices may vary by Plan and are reviewed and updated frequently. Caremark's MAC prices reflect our best understanding of marketplace pricing and product availability.

Caremark determines MAC generally at a product level for generic and multi-source brand products. This determination includes a review of marketplace dynamics, product availability, and different Pricing Sources. Pricing Sources may include Medi-Span, MAC lists published by CMS, National Average Drug Acquisition Cost (NADAC) published by CMS, Predictive Acquisition Cost (PAC) developed by Glass Box Analytics, and if available, wholesalers and retail pharmacies. MAC prices are subject to change, which can occur at least on a weekly basis and are based on marketplace trends and dynamics and price fluctuations. MAC price lists and/or pricing formulas are Caremark confidential and proprietary information informed by various Pricing Sources and Caremark's estimation of net acquisition costs.

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

Provider may access the Pharmacy Portal to obtain current MAC prices and upcoming MAC prices based on Caremark's MAC price update schedule, including for Medicare Part D Plans. To locate current or upcoming MAC price information, utilize the "MAC Price Look Up" feature of the Pharmacy Portal available through a secure website: **rxservices.cvscaremark.com**. Providers can also request a MAC list by submitting a "Pharmacy MAC List Request" found online at **caremark.com/pharminfo** (under Digital Enrollment Forms) to **MACInquiries@CVSHealth.com**.

6.05 Eligible Person Fees and Amounts

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

6.06 Claims Payment and Other Fees

6.06.01 Remittance Advices

Provider will receive a remittance advice for claim transactions within a payment cycle. Paper remittance reports are distributed by mail; 835s are posted to a secure portal. Caremark payments to Provider may reflect adjustments for claims reversals, resubmissions, or amounts owed by Provider to a Plan Sponsor under a Provider Agreement between Provider and a Plan Sponsor.

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

CVS Caremark
Attn: Finance, MC 019
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

6.06.02 Disputed Claims, Collected Fees, Amounts, or Recoupments

Provider is required to review remittance advices and reports for programs with performance, clinical, or health care outcomes measures received from Caremark. Notwithstanding any provision in the Provider Agreement, if Provider disputes a claim, collected fees, amounts, or recoupments due to failure to pay the contractual reimbursement amount, Provider must notify Caremark in writing within one hundred eighty (180) days of the fill date, date of collected fees, amounts, or recoupments, receipt of Performance Network Program report assessing network variable rates, or within a longer period required by applicable Law, listing details of the disputed claim or payment, collected fees, amounts, or recoupments. For claim disputes regarding a remittance advice, Provider's notification of a disputed claim, collected fees, amounts, or recoupments must include the fill date, prescription number, Eligible Person ID number, and Provider NPI or NCPDP. For disputes regarding a Performance Network Program report, Provider's notification of a disputed network fee must include the specific fee and network at issue. Provider should include a copy of the remittance advice or Performance Network Program report, if possible, and must provide the specific reason for the dispute. If Provider fails to notify Caremark in a timely manner or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims, collected fees, amounts, or recoupments as set forth in the remittance advice or assessment of fees in the Performance Network Program report for the applicable cycle or trimester, except for any overpayments made to Provider.

Notifications may be mailed to:

CVS Caremark
Attn: Network Services, MC 023
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

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

6.06.03 Claim Adjustment

Notwithstanding any provision in the Provider Agreement, if Provider requests an adjustment to a claim (e.g., to correct claims information submitted by Provider), Provider must notify Caremark in writing within one hundred eighty

(180) days of the fill date, or within a longer period required by applicable Law. If Provider fails to notify Caremark in a timely manner, or in the manner required, Provider is deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the remittance advice for that cycle. A $2.50 per claim assessment, where permitted by applicable Law, will be applied where Caremark or Plan Sponsor in writing agree to Provider's request for non-electronic submission or reversal of claims.

Claim adjustment requests must list the fill date, prescription number, Eligible Person ID number, Provider NPI or NCPDP, refill code and authorization number, the specific reason for the claim adjustment requested, and the information necessary to make the requested adjustment. To request a copy of the claim adjustment template, or for questions regarding data submission, contact the Pharmacy Help Desk.

Claim adjustment requests may be emailed to: **PharmacyAdjustment_Request@CVSHealth.com**

Claim adjustment requests may be mailed to:
CVS Caremark
Attn: Adjustment Services, Pharmacy Corrections, MC NBT-4
2211 Sanders Rd
Northbrook, IL 60062

Providers may be required to submit claim adjustment requests electronically.

6.07 Recoupment and Adjustments

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

6.08 Workers' Compensation

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

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

6.09 Consumer Card

Caremark may from time to time offer Provider participation in Caremark or Plan Sponsor-specific consumer card networks. A consumer card network offers an Eligible Person access to a discounted price for a Covered Item without using funding from an insurance product. The Eligible Person may be responsible for a consumer card administration fee at the point of service which will be included in the Patient Pay Amount and deducted from a future remittance.

Provider acknowledges and agrees that Caremark may elect to partner with third parties for the administration of consumer card programs for participating Plan Sponsors. Caremark may forward any claim submitted to Caremark to a third party for the purposes of processing a consumer card claim under a contract between Provider and the third party and return the third party's claim response to Provider. To the extent Provider is contracted with that third party, Provider agrees that such claims will be reimbursed pursuant to the Provider's contract with the third party, and not the Caremark Provider Agreement. Caremark will make available a list of the third parties and additional technical information on the Pharmacy Portal.

6.10 Provider Suspension

Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or cancellation of checks, in whole or in part, and/or claim adjudication suspension) of Provider if required by applicable Law, or if Caremark has reason to believe Provider has engaged in, or is engaging in,

any activity which (1) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public; (2) implies a failure to maintain proper licensure and related requirements for licensure; (3) otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement; (4) is a breach of the Provider Agreement; (5) alters the dispensing patterns of the Provider sufficiently to indicate potential fraud, waste, or abuse; or (6) constitutes potential fraud, waste, or abuse. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement.

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

6.11 Directories

Caremark and Plan Sponsors may list Provider in directories and databases for distribution to, and use by, Eligible Persons, Plan Sponsors, and others as Caremark or a Plan Sponsor determines necessary. Additionally, Caremark may display Provider, if applicable, in preferred provider performance initiatives in paper, web-based directories, or Plan Sponsor reporting. Refer to section **13.01 Advertising and Trademarks** of the Provider Manual.

Caremark has a requirement to maintain accurate directories of Dispensing Pharmacies so that Eligible Persons can quickly find pharmacies to fill their prescriptions. Therefore, Providers that have no dispensing activity of Covered Items for a period of time may be immediately removed from the network as determined at Caremark's sole discretion. Additionally, at Caremark's sole discretion, Provider's credentials may be updated without Provider's confirmation using alternative data sources. Refer to section **2.05.01 Notification of Change in Documentation and Other Information** of the Provider Manual for more information.

6.12 Collection of Regulatory or Other Governmental Agency Assessment

Provider agrees that Caremark is authorized to collect or retain the entire amount of any monetary penalty, fee or other obligation assessed against a Plan Sponsor or Caremark by a federal, state, or other governmental agency that is based on the federal, state, or governmental agency's determination of a violation caused by acts of the Provider.

7. Compliance Reviews

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

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

7.01 Types of Compliance Reviews

Compliance Reviews include, but are not limited to:

- Concurrent/Daily Review
- Medicare/Medicaid Review
- Telephone, fax, or email inquiries
- Provider Tax determinations and legal basis for calculation of such Provider Tax

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

1. Submitting incorrect data for claims submission;
2. Failing to provide documents or information by the specified deadline requested by Caremark pursuant to the Provider Agreement;
3. Refusing to accept an identification card for an Eligible Person;
4. Refusing to service an Eligible Person because of the reimbursement rate;
5. Failing to submit a claim for a Covered Item for an Eligible Person;
6. Disclosing Confidential Caremark Information;
7. Submitting the incorrect applicable DAW code;
8. Submitting inaccurate Usual and Customary Prices or ingredient costs;
9. Submitting a Product Identifier that does not match the product dispensed to the Eligible Person or submitting a Product Identifier that does not match the product used to prepare the compounded product dispensed to the Eligible Person;
10. Non-adherence to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual;
11. Not dispensing an emergency supply of a Covered Item to an Eligible Person as required by applicable Law;
12. Non-adherence to section **4.16 Software Certification** of the Provider Manual;
13. Blocking, avoiding, evading, failing, or otherwise refusing to accept telephone calls, fax transmissions, emails (or other electronic means of communication, e.g., Pharmacy Portal secure messages), or postal or courier deliveries from Caremark during Provider's hours of operation;
14. Separating cash and third-party prescription business; and
15. Owning, operating, or affiliating with a non-participating Provider to manipulate Eligible Person prescription claims processing or pricing.

Providers not in compliance with Caremark Documents may be subject to assessment of non-compliance charges (refer to section **7.02 Non-Compliance Charges** of the Provider Manual) as well as subject to audit review and Chargeback for non-compliance actions (e.g., modifying a Usual and Customary Price or ingredient cost, submitting a Product Identifier other than actual product dispensed).

7.02 Non-Compliance Charges

Caremark may find it necessary to perform claims review. Provider agrees that Caremark may review submitted claims and, unless prohibited by Law, charge a reasonable amount to the Provider consistent with the resources required to perform the review. These reviews may be performed on all claims submitted by the Provider and may include, but

not be limited to, consulting with the Prescriber or Eligible Person; review of copayment collection evidence, original prescription, prior authorization documentation, etc.; and other reviews to confirm compliance with the Provider Manual and applicable Law.

Caremark may assess against Provider a $500 administration charge for an initial occurrence of non-compliance or for each non-compliant submitted claim, increasing in $500 increments for subsequent non-compliant events (e.g., $500, $1,000, $1,500). Caremark has the right to offset, if consistent with applicable Law, in whole or in part, against any amounts owing to Provider under the Provider Agreement. Amounts owed to Caremark include, but are not limited to, amounts owed for charges for non-compliance pursuant to the Provider Agreement or any Third-Party Agreement, or claims submitted in breach of the Provider Agreement. Provider also may receive a corrective action required (CAR) notice, with additional requirements and remedial measures, as outlined in section **8.08 Corrective Action Plan** of the Provider Manual.

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

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

7.03 Additional Information Regarding Compliance Reviews

1. Provider must be reachable by Caremark during hours of operation communicated by Caremark pursuant to section **3.02.01 Hours of Operation** of the Provider Manual and based on the contact information (as updated) that Provider specified to Caremark as part of enrollment or credentialing. It is essential that Provider keep contact information up to date to ensure reminders and other important communications are received. Refer to section **2.05 Notification to Caremark** of the Provider Manual. See also section **6.10 Provider Suspension** of the Provider Manual.
2. Documents and records subject to review include, but are not limited to, the following:
    a. Prescription hard copies or electronic prescription records (refer to section **3.05 Records** of the Provider Manual)
    b. Computer records/documentation
    c. Dispensing records that include quantities and dates dispensed
    d. Signature logs (refer to section **3.05.02 Signature Log – Hard Copy or Electronic** of the Provider Manual)
    e. Delivery logs with tracking information for mailed or home/business delivered prescriptions (refer to section **3.05.02 Signature Log – Hard Copy or Electronic** of the Provider Manual)
    f. Prescription label and dispensing label
    g. Compound record and subformulations, which must include at minimum, actual Product Identifiers of all items used, lot numbers, expiration dates, compounding instruction, final compounded dosage form, signature of verifying pharmacist, and certificate of analysis. Provider must keep compound records for the same time period as required for prescription hard copies or electronic prescription records. Refer to chapter **4. Claims Submission** of the Provider Manual
    h. Evidence of copay collection including proof of financial transaction. Refer to chapter **3. Pharmacy Services and Standards** of the Provider Manual
    i. Methodology used to determine appropriate beyond-use date
    j. Claim reversal records, including confirmation of reversal acceptance from Caremark
3. For claim submission requirements refer to chapter **4. Claims Submission** of the Provider Manual.
4. Caremark from time to time supplies network Providers with basic information on the appropriate billing of Covered Items to help prevent audit discrepancies and non-compliance with the Caremark Provider Manual. Pharmacy audit tips are posted on the Pharmacy Portal at **rxservices.cvscaremark.com**. Provider will be responsible for monitoring and reviewing pharmacy audit tips on the Pharmacy Portal. Refer to sections **1.04 Pharmacy Communications** and **1.05 CVS Caremark Pharmacy Portal** of the Provider Manual.
5. For additional claim processing information, refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.
6. Pharmacy Help Desk representatives do not have authority to waive or modify Provider Agreement provisions (e.g., claim submission requirements, audit documentation, credentialing documentation, non-compliance). For audit purposes, Provider must always maintain accurate documentation consistent with Caremark requirements to support overrides submitted, including overrides recommended by Pharmacy Help Desk representatives.

8. Professional Audits

As a service to its Plan Sponsors and Eligible Persons, and to educate Providers in complying with the Provider Agreement, Caremark engages in an on-going audit program. The audit program also serves to protect against fraud, waste, and abuse. As part of this program, Caremark may conduct reviews and audits of claims prior to payment to ensure compliance with the Provider Agreement. Caremark may also audit claims post-payment. The positive adjudication of any claim does not limit or preclude Caremark's ability to review or otherwise audit or recoup that claim. As consistent with applicable Law, if the audit requires use of clinical or professional judgment, the audit must be conducted by or in consultation with a Licensed Pharmacist.

8.01 Types of Audits

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

8.01.01 On-Site Audits

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

8.01.02 Expanded Audits

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

8.01.03 Desktop Audits

For a desktop audit, Provider is contacted via telephone, fax, or through the mail to satisfy records and documentation requirements for limited reviews [e.g., Medicare Drug Integrity Contractor (MeDIC) requests, CMS audits, Plan Sponsor audit inquiries, and compliance audits]. Records and documentation requested must be provided in a timely manner not to exceed ten (10) days following the original request or according to applicable Law.

To satisfy Provider information requirements for Medicare Part D audits, Caremark will occasionally contact Provider via telephone. Compliance with Medicare Part D audits conducted telephonically is required, and if the Caremark auditor is denied access to Provider's information, Provider is deemed non-compliant. Caremark has the right to recoup one hundred percent (100%) of the amount for the claims in question, with such amount becoming immediately due and owing to Caremark.

Failure to provide Provider information, records and/or documentation may result in non-compliance charges, submission of a corrective action plan (CAP), or potential termination from the provider network.

8.01.04 Audits by Government Agencies

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

8.02 Professional Audits Rights

During the term of the Provider Agreement and for two (2) years following the termination of the Provider Agreement (or such time permitted under applicable Law), Caremark has the right to audit Provider's records and documents, facility, and practices as Caremark reasonably determines are necessary to evaluate Provider's compliance with the Provider Agreement and applicable Law. Caremark's audit may cover any claim submitted by Provider or Eligible Person to Caremark or Plan

Sponsor for adjudication, regardless of the method of submission. To the extent allowed by Law, if there is a conflict between the Provider Manual and applicable Law with respect to an audit of Provider, the audit is subject to the stricter provision.

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

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

Throughout the audit process:

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

Provider authorizes Caremark to release Provider's information, records, and documents to governmental authorities (and their agents), Plan Sponsors, and wholesalers upon request. Refer to section **8.01.04 Audits by Government Agencies** of the Provider Manual. Caremark reserves its rights under section **13.03 Confidentiality** of the Provider Manual.

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

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

Provider must notify Caremark in the event of a change in the pharmacy's physical location prior to the change. Refer to section **2.05 Notification to Caremark** of the Provider Manual.

8.03 Documents and Records Production Related to Audits

Provider must provide Caremark with all requested documents, information, and records as Caremark reasonably determines are necessary to evaluate Provider's compliance with the terms of the Provider Agreement and applicable Law, and Provider must fully comply with such requests, including the delivery of all requested documents and records to Caremark by the specified due date and without charge to Caremark. If Provider fails to provide requested documents and records, the entire amount of the paid claim for which documents and records were not provided may be recouped. Caremark reserves the right to deny a request for extension of a documentation due date.

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

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

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

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

8.04 Documents and Records Subject to Audit

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

- Prescription records - scanned images of hard copies must include both the front and back images of the prescription hard copy and the prescription hard copy must be retained and retrieved if requested. Prescription hard copies or scanned images of prescription hard copies must be legible by Caremark (refer to section **3.05 Records** of the Provider Manual)
- Signature logs
- Delivery logs with tracking information for mailed or home/business delivered prescriptions
- Daily prescription logs
- Wholesaler, manufacturer, and distributor invoices (with NDC, product names, quantity, package size, etc.)
- Transaction Statement, Transaction History, and Transaction Information and Documentation as defined in section **8.05 Supply of Covered Items; Purchase Invoices** of the Provider Manual
- Refill information
- Prescriber information
- Patient profiles/Prescriber orders
- Records to validate Usual and Customary Price
- Prescription label and dispensing label
- Provider system report of Pharmacy Services reversed, returned to stock, or not dispensed with confirmation of reversal of the claim submission
- Recorded diagnosis on prescription hard copy or maintained in the computer system for all Medicare Part B Pharmacy Services dispensed under a Medicare Part D Plan
- Record of Eligible Person location (e.g., skilled nursing facility, assisted living facility) when claim is dispensed
- Records of transfer/sale between providers of products used for Pharmacy Services
- Records of prescription transfers, including evidence of Eligible Person's express permission to Provider to transfer their prescription to another pharmacy
- Medication or product pricing brochures for cash customers (e.g., paper pamphlet, promotional signage, internet listing)
- Patient consent and administration record of vaccine claims (combination vaccine/administration)
- Evidence of copay collection including proof of financial transaction [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash]. If the Patient Pay Amount is reduced due to a coordination of benefits (COB), Provider must provide evidence of the claim adjudication to other payer(s)
- Documents pertaining to individualized determination of financial need or exhaustion of reasonable Patient Pay Amount collection efforts. Refer to section **3.03.01 Collection of Patient Pay Amounts** of the Provider Manual
- Proof of completion of annual Medicare Part D Fraud, Waste and Abuse (FWA) training and General Compliance Training (GCT)
- Verification that Provider has reviewed the Office of Inspector General (OIG), List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) exclusion list as required by section **2.10 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual
- Prescription record documentation for Medicare Part D Enrollees with diagnosis code and/or clinical information to establish coverage determination for accurate Medicare coverage (e.g., Hospice, Part B vs. Part D, ESRD)
- Signed Prescriber or patient attestation legitimizing the dispensing of the prescription if a prescription hard copy, medication order, patient signature log or patient delivery log is not retrievable. Prescriber attestations must be written on the Prescriber's business letterhead or on the Prescriber's prescription. Attestations provided by the Prescriber must clearly indicate the source of the attestation (i.e., clearly visible fax signature that the attestation originated from the Prescriber's office or Prescriber's stamp on the attestation)
- All records acquired in the purchase of a pharmacy or in the purchase of pharmacy files
- Documentation substantiating transmission of Submission Clarification Codes (SCC) or override codes
- Evidence of verification of legitimate Prescriber/patient relationship if Provider knows or reasonably should know that there is not a legitimate Prescriber/patient relationship
- Collaborative practice agreement(s)
- Credit Card Merchant Account Report directly from the entity creating the documentation to ensure objectivity, including evidence of settlement and payment through bank records

- Policies and procedures related to all Provider operations including, but not limited to, collection of Patient Pay Amounts and inventory controls
- Documents to evidence that Provider is compliant with their own policies and procedures and/or corrective action plan
- Any document deemed necessary by Caremark to determine network Provider's compliance with any terms and conditions set forth within this Provider Manual
- Refer to section **7.03 Additional Information Regarding Compliance Reviews** of the Provider Manual for required Multi-Ingredient Compound Documents

Provider acknowledges that Health Insurance Portability and Accountability Act of 1996 ("HIPAA") specifically permits a covered entity, such as Provider, to disclose Protected Health Information (PHI) for its own payment purposes (see 45 C.F.R. 164.502 and 45 C.F.R. 154.501). Provider further acknowledges that in order to receive payment from Caremark, Provider is required to allow Caremark to conduct audits of its prescription and other pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws. Additionally, Provider recognizes that Caremark audit staff may be exposed to or otherwise become aware of certain confidential, protected, and individually identifiable health information of patients who are not Eligible Persons during the course of the audit review, and that such disclosures by Provider to Caremark are incidental to the payment disclosures and are therefore permitted by HIPAA under 45 C.F.R. 164.502(a)(iii) provided that reasonable safeguards are implemented by Provider to limit such incidental disclosures. Caremark will maintain confidentiality of this information and will not disclose, publish, or otherwise reveal any of this confidential information except as necessary to conduct its audit pursuant to applicable Law.

8.05 Supply of Covered Items; Purchase Invoices

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

For those products for which a Transaction Statement, Transaction History, and Transaction Information are not required by the DSCSA, Provider must maintain records of the exact quantities purchased, name of the Authorized Trading Partner, product name(s), NDC(s), date(s) of purchase, and proof of payment [e.g., copies of credit card receipts, canceled checks (front AND back)] (collectively "Documentation"). For those products received from other pharmacies, Provider must obtain and maintain the entire Transaction Statement, Transaction History, and Transaction Information from the selling entities. Failure to acquire and maintain records will result in the products received from other pharmacies being ineligible to be dispensed to Eligible Persons. Unless permitted by applicable Law, Provider must not dispense or submit claims for products which are foreign-sourced, samples, returned, recalled, expired, or otherwise "suspect", as defined below. For diabetic testing supplies, Provider must use diabetic products that have been sourced either from within the manufacturer's authorized distribution channel ("Authorized Distribution Network") or purchased directly from the manufacturer.

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

The parties hereby designate manufacturers of diabetes testing products as third-party beneficiaries of this **Supply of Covered Items; Purchase Invoices** section having the right to enforce the paragraphs related to the requirement to purchase from the manufacturer directly or from its Authorized Distribution Network.

Provider's receipt of products when Provider knows, or reasonably should have known, that the product is suspect may result in Chargeback of claims and other remedies available to Caremark including, but not limited to, termination of the Provider Agreement. For purposes of this section "suspect" means a product that is potentially counterfeit, diverted, or stolen; is potentially intentionally adulterated such that the product would result in serious adverse health consequences or death to humans; is potentially the subject of a fraudulent transaction; or appears otherwise unfit for distribution such that the product would result in serious adverse health consequences or death to humans.

Provider must make available to Caremark Transaction Statement, Transaction History, and Transaction Information, and Documentation as part of Caremark's audits. Provider must fully cooperate with Caremark in audits or in the course of any investigation of suspected or reported violations of this section. Caremark's audit may involve selecting a date range for aggregate purchase invoice review. Provider's purchases occurring within the date range of the aggregate purchase invoice review, or thirty (30) days prior thereto, must be sufficient to support the total quantity dispensed by Provider (or provided to Eligible Persons) as reflected in the claims billed to Caremark during the same date range of the aggregate purchase invoice review. Caremark will not consider purchases occurring outside of thirty (30) days prior to the selected date range unless: (1) Provider notifies Caremark in writing of its bulk purchase of a Covered Item no later than twenty-one (21) days after the bulk purchase; and (2) Caremark acknowledges receipt of the bulk purchase notice. Acknowledgement by Caremark of receipt of the bulk purchase notice shall be made in writing for Provider's records; however, acknowledgement by Caremark alone does not guarantee acceptance of the bulk purchase, which will be reviewed in accordance with the same standards applied to non-bulk purchase invoices in accordance with the terms of the Provider Manual and applicable Law. If Provider has not purchased sufficient Covered Items to substantiate the quantity of claims billed, those claims may be subject to Chargeback and other remedial action. If Provider fails to timely provide all the requested Documentation in accordance with this section, one hundred percent (100%) of the amount for the paid claims audited is subject to Chargeback and other remedies available to Caremark including, but not limited to, termination of the Provider Agreement.

Notification of bulk purchases may be made by email to **PharmacyAudit@CVSHealth.com**, or to the following address:
CVS Caremark
Attn: Bulk Purchase Notification, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

8.05.01 Invoice Documents and Records Maintenance

Provider must maintain any Transaction Statement, Transaction History, and Transaction Information provided to Provider pursuant to the DSCSA and any regulations promulgated under the DSCSA for the period required by applicable Law and any Documentation during the term of the Provider Agreement and for two (2) years after the termination of the Provider Agreement.

8.06 Medicare Part D Requirements

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

- Long-term care billing documents
- Correct use of valid Patient Residence codes (the term "correct" means, for example, submitting the actual Patient Residence code for patients where they physically reside rather than a Patient Residence code for a recognized LTC/ALF where the patient previously resided). Refer to section **10.07 Special Instructions for Participating LTC Providers** of the Provider Manual
- Correct use of Pharmacy Service Type values. Refer to section **10.06.02 Pharmacy Service Type and Patient Residence Requirements** of the Provider Manual
- Compliance with "CMS-10147 Medicare Prescription Drug Coverage and Your Rights" pharmacy notification
- Documentation to establish coverage determinations (e.g., Hospice, Part B vs. Part D, ESRD)
- Documentation to prove that Provider has reviewed the OIG LEIE and the SAM exclusion list as required by section **2.10 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual to confirm that no Prescriber transmitted on a Medicare Part D claim is on any exclusion list
- Documentation or information requested which relates to a Medicare Part D claim dispensed by Provider but reimbursed directly to other parties, including the Part D Enrollee
- Documentation substantiating any Submission Clarification Codes (SCC) or override codes transmitted on a Medicare Part D claim

Documentation submitted must comply with guidance set forth by CMS or any other applicable regulatory body or its designated auditor.

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

For further requirements refer to chapter **10. Medicare Part D** of the Provider Manual.

8.07 On-Site and Expanded Audit Resolution – Appeals Process

As part of an audit, Caremark may identify claim discrepancies. If Caremark identifies claim discrepancies Caremark will send Provider an initial discrepancy report along with documentation guidelines (refer to **Appendix A – Appeals Process Documentation Guidelines** of the Provider Manual) that show how Provider may address an initial discrepancy and validate the audited claim through a written appeals process.

If Provider chooses to appeal the initial discrepancies Provider must respond to Caremark in writing within thirty (30) days, or other timeframe required by applicable Law, with supporting documentation for the discrepant claim in accordance with the documentation guidelines or the Provider Manual. Documentation must be transmitted to Caremark via certified mail, fax, secure electronic message, Federal Express, United Parcel Service, or any other certified carrier (with delivery confirmation) and must be received by the due date specified by Caremark. Provider may contact the Pharmacy Performance department at **1-866-488-4709** prior to the documentation due date to request an extension of the documentation due date. Caremark reserves the right to deny a request for extension.

Upon review of Provider's appeal documentation, or at the end of the designated appeal period if Provider has not submitted appeal documentation, Caremark will issue a final audit report. Discrepant claims that are not documented and validated in accordance with the documentation guidelines or the Provider Manual are detailed in the final discrepancy report and are due and owing to Caremark as of the expiration of the 30-day appeal period or other timeframe required by applicable Law; however, Caremark has the right to offset, if consistent with applicable Law, against amounts owed to Provider before the expiration of the 30-day period, or other time period required by Law, for any discrepant claims as allowed for under section **6.10 Provider Suspension** of the Provider Manual. Audit discrepancies are detailed in a final audit discrepancy report.

Refer to section **14.09 Arbitration** of the Provider Manual for the dispute resolution process once the final audit discrepancy report is complete.

The parties agree that Caremark will incur operating costs and expenses arising out of or related to conducting audits that are difficult to reasonably estimate; as such, if the final audit Chargeback exceeds $10,000, Provider must also reimburse Caremark twenty percent (20%) of the total final audit Chargeback, not to exceed $100,000, for operating costs and expenses arising out of or related to conducting the audit and collecting the final audit Chargebacks, where consistent with applicable Law. Provider agrees that this twenty percent (20%) audit costs and expenses reimbursement represents a reasonable method to estimate the operating costs and expenses arising out of or relating to conducting audits.

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

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

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

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

Once Provider is on notice of an on-site or expanded audit Provider must not adjust or reverse claims that are the subject of the audit; Caremark will perform appropriate adjustments and reversals at the conclusion of the audit process. Following receipt of a notice of audit, the reversal of claims that fall within the time period to be audited may be considered as evidence of FWA.

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

8.08 Corrective Action Plan

A corrective action required (CAR) notice may be sent to Provider requiring Provider to submit to Caremark a corrective action plan (CAP) that in detail describes Provider's plans to resolve identified issues such as audit findings, dispensing errors, failure to respond to audit requests, failure to correct repeated verbal and/or written warnings regarding non-standard retail pharmacy model practices, or as may be required by applicable Law. Provider must respond to any request for information and action in a CAR notice. Provider's response must be submitted by the date provided on the CAR and must include a CAP. Provider's CAP must include applicable documentation and policies and procedures as specified in the CAR notice to support Provider's CAP. As part of the CAP process, Provider may be assessed a per claim review fee where permitted by applicable Law for oversight claim activity during the CAP period (refer to section **7.02 Non-Compliance Charges** of the Provider Manual). If Provider fails to fully respond to a CAR notice or any other request for information and action as part of the CAR/CAP process, fails to follow the CAP, or requires a CAR/CAP for the same or similar issues, Caremark reserves the right to exercise its termination rights under the Provider Agreement, along with other available remedies.

8.09 Potentially Fraudulent Activity

If Provider suspects that (1) potentially fraudulent prescriptions are being presented to Provider for purposes of billing and/or dispensing prescription items, (2) the prescription is being presented for diversion purposes, (3) an Eligible Person's identification information has been compromised, or (4) that other improprieties regarding claims are occurring, Provider must notify Caremark by telephone at **1-877-841-1851** or by written correspondence at:

CVS Caremark
Attn: Network Performance, MC 020
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

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

- Eligible Person presenting a forged or altered prescription
- Eligible Person presenting a prescription not written by the Prescriber identified
- Eligible Person calling in their own prescription
- Eligible Person presenting a prescription for an ineligible person or fictitious family member

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

9. Medicaid

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

9.01 Compliance with State and Federal Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Medicaid Eligible Person is made, in whole or in part, from state and federal funds, which subjects Provider to laws, including, but not limited to, the False Claims Act, the Anti-Kickback Statute, and HIPAA. Provider must comply with applicable Laws including minimum standards of pharmacy practice, and which may also include additional provisions from federal Medicare Part D program requirements. Refer to chapter **15. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda (located on the Pharmacy Portal, at **rxservices.cvscaremark.com**). Provider agrees to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions. [42 C.F.R. § 438.230(c)(2)]. Provider acknowledges that Provider's ability to provide Pharmacy Services under the Provider Agreement for Medicaid Eligible Persons may be revoked if it is determined that Provider has not performed satisfactorily [42 C.F.R. § 438.230(c)(1)(iii)].

9.02 Enrollment with State Medicaid

Pursuant to 42 C.F.R. § 438.602(b), Provider shall ensure that it is enrolled with each state Medicaid agency for which Provider provides Pharmacy Services under the Provider Agreement. Provider agrees that if it is not enrolled with the applicable state Medicaid program, it may not provide Pharmacy Services under the Provider Agreement for that state Medicaid program's Eligible Persons. It is Provider's responsibility to ensure that it is enrolled with each applicable state Medicaid agency as appropriate, and Provider must maintain that Medicaid enrollment with all applicable Medicaid agencies.

9.03 Medicaid Credentialing

Provider shall comply with Caremark's credentialing requirements. Failure to do so impacts Plan Sponsors in terms of compliance to their governing body(ies) and impacts Eligible Persons in terms of Eligible Persons' ability to locate Provider's physical location or contact information in a prompt manner. Provider must provide Caremark with documentation and other information that is required to comply with "Disclosure of Information by Providers and Fiscal Agents" (42 C.F.R. Part 455, Subparts B, E); otherwise, Provider may be subject to termination or other available remedies. Provider is required to notify Caremark and, where applicable, the Plan Sponsor, and provide updated, accurate information such as physical address, city, state, ZIP Code, telephone number and fax number; changes to location; and contact information in a timely manner not to exceed ten (10) days or according to applicable Law or enrollment agreement. Failure to submit updates of the required information by the due date may result in penalties including, but not limited to, assessment of non-compliance charges, submission of a CAR (corrective action required) and CAP (corrective action plan), or potential termination from the provider network. Refer to chapter **2. Credentialing** of the Provider Manual for additional information.

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

To the extent required by applicable Law, Providers only enrolled in a state Medicaid program may not be charged or assessed enrollment or credentialing fees. Send questions via the Pharmacy Provider Question Form found at **caremark.com/pharminfo**. Scroll down and click on "Forms and Guides". Under Digital Enrollment Forms, select Pharmacy Enrollment Self-Service, then click on "Go to enrollment self-service". Finally, submit your question using the online form "Pharmacy Provider Question Form".

9.04 Fraud, Waste and Abuse Compliance Program

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

9.05 Inspection and Audit of Records and Access to Facilities

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

9.06 Claims Submission Requirements for Medicaid

Additional Plan Sponsor-specific information, such as claims submission requirements for 340B drugs, may apply as specified in notices to Provider or in the applicable payer sheet(s). Refer to the applicable payer sheet(s) online at **caremark.com/pharminfo**.

9.06.01 Unique RXBIN/RXPCN (or RXIIN/RXPCN) Requirement for Medicaid

Provider must include RXBIN or Issuer Identification Number (RXIIN), RXPCN, and RXGRP values on submitted claims. Eligible Person profiles must be updated accordingly. Caremark will continue to communicate unique RXBIN/RXPCN/RXGRP (or RXIIN/RXPCN/RXGRP) combinations of Plan Sponsors. Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

9.07 Medicaid Coordination of Benefits

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

Refer to section **4.10 Coordination of Benefits** of the Provider Manual. For complete technical information on COB, refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

9.08 Prior Authorization

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

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

9.09 Denial of Services

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

9.10 Cultural Competency

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

9.11 Home Delivery

A Medicaid beneficiary may not be charged for the expense, or any portion of an expense, as the result of a Covered Item being mailed, shipped, or delivered (including curbside delivery), etc.

9.12 Directories

Provider shall provide Caremark with all information that may be needed in connection with Caremark's initiatives to comply with 42 C.F.R. § 438.10 concerning pharmacy directories. Additionally, at Caremark's sole discretion, Provider's credentials may be updated without Provider's confirmation using alternative data sources.

9.13 Overpayment

Provider shall report to Caremark when it has received an overpayment from Caremark. Provider shall return the identified overpayment to Caremark within sixty (60) days of identifying the overpayment and notify Caremark in writing the specific reason for the overpayment and how the overpayment was identified by the Provider. Provider is requested to provide data including, but not limited to, prescription numbers, dates of fill, and claim numbers. Provider shall mail the overpayment notification and check (cashier's check preferred) in the amount of the overpayment to:

CVS Caremark
Attn: Government Overpayment Notification, MC 020
9501 E Shea Boulevard
Scottsdale, AZ 85260

9.14 Transition Fill

Transition fill is a process by which new members, as well as existing members, are provided a transition supply of needed drugs when appropriate, as required by CMS and by state Medicaid agencies. Transition fill parameters are defined by state; however, clients can add additional drugs at their discretion. Transition fills will be implemented according to the following rules: (1) the Transition fill period will be defined by the state, or the client when not defined by the state; and (2) a Medicaid beneficiary may receive a certain number of transition fills within their transition fill period or a specified cumulative days' supply (CDS), dependent upon state requirements and/or client setup. Transition fill eligible drugs are defined by the state, and transition fill will override most utilization management (UM) edits as required by the state and/or client.

10. Medicare Part D

The provisions in this chapter may apply to other sections of the Provider Manual as applicable.

10.01 Medicare Part D Network Standards

To the extent Provider provides Pharmacy Services to a Part D Enrollee, Provider must comply with the following terms contained in chapter **10. Medicare Part D** of the Provider Manual. Unless specifically indicated otherwise, these terms apply to all Providers who provide Pharmacy Services to a Part D Enrollee (including retail, home infusion, long-term care (LTC), and Indian Health Services/Tribal/Urban Providers). Provider acknowledges that CVS Caremark Part D Services, L.L.C. together with certain other designated affiliates of Caremark Rx, L.L.C. (collectively, "Caremark" for the purposes of this section) are responsible for providing Part D services on behalf of Part D Plan Sponsors. All capitalized terms used in chapter **10. Medicare Part D** of the Provider Manual will have the same meaning as in the applicable **Addendum to the Caremark Provider Agreement: Terms of Participation in Medicare Part D,** or the **Glossary of Terms** in the Provider Manual.

10.01.01 Network Participation

For any Part D plan year, and to ensure adequate access to retail network pharmacies for Part D Enrollees, Provider must provide Caremark with written notice by no later than March 31 of the prior calendar year, or other time as specified in the cover letter accompanying Medicare Part D network enrollment form solicitations, if Provider will not be participating in a Medicare Part D network including, but not limited to, the retail, long-term care, and home infusion networks for that plan year. For example, if Provider will not be participating in the Medicare Part D Retail Pharmacy network for the 202X plan year, it must notify Caremark in writing by no later than the specified date indicated in the solicitation for that Medicare Part D network enrollment form. If such timely written notice is not given, Provider must participate in such Medicare Part D network for the entire Part D plan year unless Provider terminates with cause its participation in accordance with the Provider Agreement. If Provider elects to participate, either passively or by signing and returning the network enrollment form (as applicable), and does not terminate from a Medicare Part D network, Provider is deemed to be in agreement to all terms and conditions (including reimbursement), as reasonable and relevant, regardless of the business model or dispenser type in which Provider identifies. Additionally, if the network enrollment forms incorporate a performance program, Provider must support all performance initiatives in keeping with the accepted terms and conditions and acknowledges that no additional dispenser-type definitions apply to a pharmacy participating in a Medicare Part D Retail Pharmacy network, in accordance with the Centers for Medicare & Medicaid Services (CMS) guidance.

The terms of section **10.01.01 Network Participation** of the Provider Manual supersede and amend any inconsistent or contrary provision in the Provider Agreement, including section **14.05.02 Termination Without Cause** of the Provider Manual, but will only apply to the extent that this section is consistent with a Part D Plan Sponsor requirement.

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

10.01.02 Compliance with Laws

Pharmacy reimbursement to Provider for Pharmacy Services for a Part D Enrollee is made, in whole or in part, from federal funds and subjects Provider to laws including, but not limited to, the False Claims Act, the Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Provider must comply with minimum standards of pharmacy practice under applicable state Law. Refer to chapter **15. Federal and State Laws and Regulations** of the Provider Manual, including state-specific addenda, posted on the Caremark Pharmacy Portal. For instructions on how to access the Pharmacy Portal, refer to section **1.05 CVS Caremark Pharmacy Portal** of the Provider Manual.

10.01.03 Delegated Activity

Provider must obtain prior written approval from Caremark if Provider wishes to delegate any activity or responsibility related to its Pharmacy Services to a subcontractor. Upon Caremark's written approval of such delegation, Provider must obtain written agreement from such subcontractor that the subcontractor will comply with all of the terms and conditions of the Provider Agreement (which includes the Provider Manual) applicable to Provider including, but not limited to, the requirement to comply with the contractual obligations specified for downstream entities in 42 C.F.R. 423.505(i)(2) and (i)(3) that relate to, among other things, retention of books and records, including prescription records, for at least ten (10) years or longer as specified in 42 C.F.R. 505(i)(2); section **2.10 Federal Health Care Programs Participation Exclusion: Pharmacy** of the Provider Manual; and chapters **4. Claims Submission** and **8. Professional Audits** of the Provider Manual. Provider's written agreement with subcontractor must provide that the agreement and/or delegated activities may be revoked (or specify other remedies) in instances when CMS, Part D Plan Sponsor, or Caremark, or any of Caremark's subsidiaries or affiliates determines that the subcontractor has not performed satisfactorily. In the event that any subcontractor is terminated by CMS or Part D Plan Sponsor, Provider must immediately notify Caremark of such termination.

10.01.04 Offshore Subcontracting

If Provider or any of Provider's subcontractors (or downstream subcontractors) receive, process, transfer, handle, store, or access Protected Health Information (PHI) of Part D Enrollees outside the United States or one of the United States Territories, Provider agrees to notify Caremark and to comply (and to require any downstream subcontractors to comply, as applicable) with the requirements specified in CMS memorandum of July 23, 2007, entitled "Sponsor Activities Performed Outside of the United States (Offshore Subcontracting)." Further, Provider agrees to submit to Caremark information to enable Caremark or Caremark's Part D Plan Sponsors to provide the "Attestation Concerning the Use of Offshore Contractors" form contained in the July 23, 2007, CMS memorandum, which includes, but is not limited to, providing to Caremark information of Provider's own or Provider's offshore subcontractor operations, safeguards to protect PHI, and auditing to ensure protection of PHI.

10.01.05 Marketing

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

10.01.06 Pharmacy Compliance and Fraud, Waste and Abuse Program

Provider agrees to adhere to the CMS Prescription Drug Benefit Manual, Chapter 9 – Part D Compliance Program Guidelines to prevent, detect, and correct Fraud, Waste and Abuse (FWA). Provider must create and maintain standards of conduct and/or compliance program policies that explain its commitment to comply with federal and state Laws, ethical behavior, and compliance program operations. These standards or policies should be distributed to all employees, including those who are directly or indirectly involved with the administration of delivery of Part D benefits, and downstream entities within ninety (90) days of hire/contract, upon revision, and annually thereafter. Provider also agrees to comply with Part D Plan Sponsor's policies and procedures, and any corrective action plans imposed by Part D Plan Sponsors or Caremark related to the Part D Program. Provider must submit copies of Provider's policies and procedures, and corrective actions related to Part D activities as requested by Caremark.

Provider must communicate to all employees, including those who are directly or indirectly involved with the administration of delivery of Part D benefits, how to report suspected or detected non-compliance or potential FWA. Provider must maintain a safe environment where employees acting in good faith can report non-compliance and potential FWA without fear of retaliation or intimidation as a result. Provider must maintain confidential and anonymous mechanisms for employees, including those who are directly or indirectly involved with the administration of delivery of Part D benefits, on how to report internally. In turn, Provider must report these concerns to Caremark, when applicable. Provider must cooperate fully with a Part D Plan Sponsor's investigative activities including providing copies of prescriptions, signature logs, and other requested documentation to support investigations.

10.01.07 Pharmacy Compliance and Fraud, Waste and Abuse Training

Providers may create, maintain, and complete their own general compliance and FWA training specific to their organizational needs. Education and training must be completed for all employees, including those who are directly or indirectly involved with the administration of delivery of Part D benefits, and downstream entities within ninety (90) days of initial hire or the effective date of contracting, when materials are updated, and annually thereafter.

Additional resources (including the CVS Health Code of Conduct) are available for all pharmacies and staff on the pharmacy website, **caremark.com/pharminfo,** under "Medicare and Medicaid Compliance Training".

For more information about Medicare Parts C and D Compliance Program requirements, visit:
cms.gov/medicare/audits-compliance/part-c-d/compliance-program-policy-and-guidance

10.01.08 CMS-10147 Pharmacy Notice

Per CMS requirements at 42 C.F.R. § 423.562(a)(3) and the regulatory guidance in section 40.12.3 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance chapter, Medicare Part D Plan Sponsors must arrange with network pharmacies to provide Part D Enrollees with a written copy of the standardized pharmacy notice when a Part D Enrollee's prescription cannot be filled under the Medicare Part D benefit at the point of sale. Providers must provide the **"CMS-10147 - Medicare Prescription Drug Coverage and Your Rights"** notice of appeal rights directly to Part D Enrollees. This form is used to instruct Part D Enrollees to contact their Part D Plan to obtain a coverage determination (prior authorization) or ask for a formulary or tiering exception if the Part D Enrollee disagrees with Plan claim response information provided to the Pharmacy.

Providers must hand this notice to Part D Enrollees when:

- The pharmacy receives a reject code (NCPDP field #511-FB) of "569"

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

- The pharmacy receives an approved message code (NCPDP field #548-6F) of "018"

  <<Provide Notice: Medicare Prescription Drug Coverage and Your Rights>> – Claim for a Part D drug submitted to the plan's Medicare Part D BIN/PCN is not covered by the Part D plan but is paid by the beneficiary per a plan-sponsored negotiated price. In this situation the member should be provided the notice entitled Medicare Prescription Drug Coverage and Your Rights.

Copies of the various versions are available at:

cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html

10.01.09 Performance Monitoring

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

10.02 General Information

10.02.01 Part D Reference Information for Pharmacists

Refer to **www.cms.gov** which contains helpful information on a variety of Medicare Part D topics for Providers. CMS frequently updates this website so check periodically for the latest information. Notwithstanding anything in the Provider Agreement to the contrary, Provider must comply with all applicable Laws (including any implementing regulations) in performing its Pharmacy Services under the Provider Agreement.

10.02.02 Medicare Part D Calls to the Pharmacy Help Desk

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

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

Medicare Part D Pharmacy Help Desk phone numbers and associated RXBIN (or RXIIN) values are found at **caremark.com/pharminfo**.

Secondary RXBINs (or RXIINs) and Plan Sponsor-specific RXBINs (or RXIINs) and phone numbers may apply as specified in pharmacy notifications or the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

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

10.03 Credentialing

10.03.01 Pharmacy Requirements for Medicare Part D Pharmacies

Provider agrees to comply with the following provisions:

1. Provider has reviewed the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) exclusion list prior to hiring or contracting and monthly thereafter for all employees, including those who are directly or indirectly involved with the administration of delivery of Part D benefits, and downstream entities as required by section **10.03.02 Federal Health Care Programs Participation Exclusion** of the Provider Manual.
2. Provider has a record retention policy in place that complies with CMS's minimum of 10-year record retention requirement and with other applicable state Law.
3. Provider has in place and provides FWA training to all employees and managers (who are directly or indirectly involved with the administration of delivery of Part D benefits) within ninety (90) days of their date of hire and annually thereafter.

10.03.02 Federal Health Care Programs Participation Exclusion

A. Prescriber

In accordance with CMS requirements, Part D Plan Sponsors must have policies and procedures in place to implement a comprehensive program to detect, prevent, and control fraud, waste, and abuse, including a process to identify any claims that were submitted for products that were prescribed by an excluded Prescriber, and a process to report and properly repay any overpayments resulting from inaccurate payments in accordance with CMS policy. The guidance also states that Part D Plan Sponsors must not pay for products prescribed by Individuals and Entities (LEIE) maintained by the Department of Health and Human Services' Office of Inspector General (OIG) comprehensive list.

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

Reject A1 <<Prescriber is Federally Excluded>>

If Provider receives this electronic message, do not resubmit the claim for processing unless, in Provider's professional judgment, it is an emergency situation. If it is an emergency situation, call the appropriate Pharmacy Help Desk contact number found online at **caremark.com/pharminfo**.

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

B. Precluded Prescriber

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

Reject 929 <<Prescriber ID is precluded>>

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

- Prescribers that are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Prescribers that have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but is not limited to, felony convictions and OIG exclusions.

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

C. Pharmacy Provider

Pharmacy Provider must review the OIG LEIE and the SAM Excluded Prescriber lists. Provider must not submit any claim to Caremark for a prescription written by an excluded Prescriber, nor should a Pharmacy Provider submit claims if Provider is excluded or debarred from participation in any federal health care program. Provider agrees that any claim submitted in violation of this section is subject to Chargeback. Refer to bullet #9 in section **4.03 Other Claim Submission Requirements** of the Provider Manual.

10.04 Pharmacy Services and Standards

10.04.01 Plan Identification Cards

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

10.04.02 General Procedures for Acknowledgement of Enrollment Letters

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

An acknowledgement letter is a letter that qualified Part D Enrollees receive from their Part D Plan in advance of the distribution of Part D Plan identification cards. The letter should contain sufficient information in order to verify a Part D Enrollee's eligibility and to submit claims to the appropriate location in order for adjudication to occur. Note, letters

confirming initial information was received but has yet to be confirmed or processed may not constitute a Part D acknowledgement letter.

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

1. If a Part D Enrollee's eligibility cannot be verified, send an E1 transaction to the Transaction Facilitator (RelayHealth) to verify the Part D Enrollee eligibility and to obtain information necessary to process claims. It is Provider's responsibility to verify Part D Enrollee is the Part D Enrollee identified in the response. For more information on E1 transactions visit RelayHealth at **medifacd.mckesson.com/e1/.**
2. If a Part D Enrollee's eligibility cannot be verified in Step 1 but Caremark is the processor, contact the appropriate Pharmacy Help Desk phone number. Refer to sections **1.03.01 Pharmacy Help Desk** and **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual.
3. If a Part D Enrollee's eligibility cannot be verified in Step 2, call **1-800-MEDICARE** to verify the Part D Plan under which the Part D Enrollee is enrolled, and if possible, verify the Part D Enrollee's eligibility information.

10.04.03 Best Available Evidence

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

1. Provider should initiate the BAE process in order for a change to a Part D Enrollee's low-income status to occur if Provider is presented with one or more of the following acceptable forms of evidence from Part D Enrollees:
    a. A copy of the Part D Enrollee's Medicaid card which includes the Part D Enrollee's name and an eligibility date during the discrepant period;
    b. A report of contact including the date a verification call was made to the state Medicaid agency and the name, title, and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
    c. A copy of a state document that confirms active Medicaid status during the discrepant period;
    d. A printout from the State electronic enrollment file showing Medicaid status during the discrepant period;
    e. A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
    f. Other documentation provided by the State showing Medicaid status during the discrepant period.
2. In addition, any one of the following forms of evidence from Part D Enrollees may establish that they are institutionalized and qualify for zero cost-sharing:
    a. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
    b. A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
    c. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.
3. Acceptable documents that may be used as BAE for demonstrating receipt of Home and Community-Based Services (HCBS) include:
    a. A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the Part D Enrollee's name and HCBS eligibility date during a month after June of the previous calendar year;
    b. A copy of a State-approved HCBS Service Plan that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year;
    c. A copy of a State-issued prior authorization approval letter for HCBS that includes the Part D Enrollee's name and effective date beginning during a month after June of the previous calendar year; or
    d. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year.

4. Once Provider has the required acceptable form(s) of evidence, Provider should either:
    a. Contact the Pharmacy Help Desk for appropriate Plan Sponsor contact information; or
    b. Consult the Caremark "Medicare Part D Plan Sponsor Information" communication distributed to Providers annually within the Pharmacy Portal at **rxservices.cvscaremark.com**.

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

10.04.04 Part D Enrollees Receiving CMS Notification on Status Change in Low-Income Subsidy

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

- Helping the Part D Enrollee submit LICS/LIS applications
- Referring the Part D Enrollee to the Social Security Administration at:

    1-800-772-1213
    ssa.gov/medicare

10.04.05 Auto-Ship Refill Programs

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

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

10.05 Claims Submission

10.05.01 Unique RXBIN/RXPCN (or RXIIN/RXPCN) Requirement - Medicare Part D

Provider must include RXBIN (or RXIIN), RXPCN, and RXGRP values on submitted claims. Part D Enrollee profiles must be updated accordingly. Caremark will continue to communicate unique RXBIN/RXPCN/RXGRP (or RXIIN/RXPCN/RXGRP) combinations of Plan Sponsors. Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

10.05.02 Payment of Clean Claims

In accordance with 42 C.F.R. § 423.520, payment for clean claims (that have been determined to be eligible for payment) will be made to Provider within fourteen (14) days (for electronically submitted claims), or thirty (30) days (for non-electronically submitted claims) from the date the claim is received. A clean claim is defined as a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. Claims from a Provider whose participation status has been suspended, in accordance with section **6.10 Provider Suspension** of the Provider Manual, are not eligible for payment unless and until such time as Provider's suspension has been lifted and any offset against amounts owed to Caremark has been processed.

10.05.03 Electronic Prescribing

Providers engaged in e-prescribing must do so in accordance with all CMS and Part D E-Prescribing standards and requirements. Refer to the following web address for specific e-prescribing requirements and their applicable compliance dates: **cms.hhs.gov/EPrescribing/**. Additional information is also available in Section 50 of Chapter 7 of the Medicare Part D Prescription Drug Manual, **cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/dwnlds/Chapter7pdf.**

10.05.04 Prescription Origin Code and Fill Number

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

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

1 = Written

2 = Telephone

3 = Electronic

4 = Facsimile

5 = Pharmacy

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

00 = Original dispensing

01 to 99 = Refill number

10.05.05 Improving Drug Utilization Review Controls

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

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

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

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

Edit Name and Description	Reject Message	Reason for Service Code	PPS Professional Pharmacy Services Code	Result of Service Code
Buprenorphine/Opioid: Identifies opioid use after treatment with a buprenorphine product for Medication Assisted Treatment (MAT).	Reject 88- PPS CODE REQD: HX BUPENORP; EXCL OPIOID	"DM"	**MØ -** Prescriber consulted **PØ -** Patient consulted **PM -** Patient monitoring **RØ -** Pharmacist consulted other source	1B - RPH determines alert is not relevant for the Rx and member 1C - Filled with a different dose 1D - Filled with different directions 1F - Filled with a different quantity 1G - Filled with a Prescriber approval 2A - RPH determines Rx should not be filled as written 4B – Dispensed, Palliative Care 4C – Dispensed, Hospice 4D – Dispensed, Cancer Treatment
Cumulative APAP Check: Checks for excessive cumulative acetaminophen (cAPAP) utilization across multiple prescriptions.	Reject 88– PPS CODE REQD: APAP EXCEEDS 4GM/DAY	"AT"		
Cumulative Morphine Milligram Equivalent (cMME): Checks for excessive opioid utilization via cumulative morphine equivalent dose (cMED) across multiple drugs and prescriptions.	Reject 922/88- EXCEEDS XXXX MME DOSE LIMIT. CONTACT MD. Reject 922/G4/88 – EXCEEDS XXXX MME DOSE LIMIT. FOR OVERRIDE PHARMACIST MUST CALL XXX-XXX-XXXX (Pharmacy Help Desk contact number) WHEN CLINICAL EXCEPTION APPLIES	"HC"		
Excessive Controlled Substance Enhancement: Intended to capture multiple controlled substance (CS) claims (for the same drug or different controlled substances) within the past 30 days.	Reject 88– PPS CODE REQD: MULT CII-V IN LAST 30 DAYS	"DM"		
Dose Check - Max Dose Multiplier: Intended to identify claims with excessively high doses. Applies to all drugs.	Reject 88– PPS CODE REQD: MAX DOSE EXCEEDED – 5X MAX	"HD"		
Multiple Pharmacies: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class at four or more pharmacies. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PHARMACIES/ SAME DRUG CLASS	"DM"		
Multiple Prescribers: Designed to identify Part D Enrollees filling multiple prescriptions within the same drug class prescribed by four or more Prescribers. Applies to all drugs.	Reject 88– PPS CODE REQD: >=4 PRESCRIBERS/ SAME DRUG CLASS	"DM"		
Multiple Long-Acting Opioids: Designed to identify Part D Enrollees on two or more long-acting opioids.	Reject 88 – PPS CODE REQD: 2 OR MORE LA OPIOIDS	"TD"		
Opioid/Benzodiazepine Drug Interaction: Designed to identify Part D Enrollees receiving a medication from both classes of drugs.	Reject 88 – PPS CODE REQD: DRUG INT OPIOIDS AND BENZO	"DD"		

Edit Name and Description	Reject Message	Reason for Service Code	PPS Professional Pharmacy Services Code	Result of Service Code
7 Day Opioid Naïve Edit: Designed to identify Part D Enrollees with no history of an opioid in the past 108 days and limit their initial supply to 7 days or less.	Reject 925: DISPENSE MAX 7 DAY SUPPLY; OR RESUBMIT WITH SCC 10 ONLY IF PATIENT HAS OPIOID RX HISTORY, CANCER-RELATED PAIN, SICKLE CELL, PALLIATIVE CARE, HOSPICE; OR CALL XXXX-XXX-XXXX	Submit SCC "10"	N/A	N/A

Do not save PPS and Result of Service codes on any prescriptions that have previously rejected for DUR. For an initial fill or any refills, Provider cannot pre-empt the reject by entering PPS codes prior to the first submission of the claim. Allow the reject to occur and then enter the appropriate PPS codes on resubmission. Entering PPS codes prior to allowing the claim to reject will cause the claim to continue to reject.

10.05.06 Medicare Part D Claims Requiring Overrides

A. Natural Disasters

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

B. Network Access

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

C. Refill-Too-Soon and Excessive Utilization Rejects

Caremark will ensure that rules preventing early refills are waived, as required by CMS, to assist those Part D Enrollees who left or lost their prescription during emergencies. The pharmacy may utilize the Submission Clarification Code (SCC) 13 and the displaced Eligible Person's impacted ZIP Code to bypass the refill-too-soon reject message. Refer to section **4.09 Natural Disasters** of the Provider Manual.

10.05.07 General Medicare Part D Submission Requirements for Coordination of Benefits

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

Provider must comply with coordination of benefits (COB) requirements for other dual eligible individuals, such as full-benefit Medicaid individuals, or other Medicaid populations when the state is responsible for covering such amounts and products to ensure the Part D Enrollee pays no more than the nominal Medicaid cost-share, if applicable.

For Medicare Secondary Payer (MSP) claims, the primary Medicare Part D RXBIN/RXPCN/RXGRP (or RXIIN/RXPCN/RXGRP) combinations should be submitted on the COB claim (refer to the Caremark "Medicare Part D Plan Sponsor Information" communication distributed to Providers annually within the Pharmacy Portal at **rxservices.cvscaremark.com**).

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

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

Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo** for additional details on how to submit Medicare Part D COB claims. Please carefully review the appropriate applicable payer sheet(s) since the submission of certain situational data elements may be required and must be submitted for processing.

10.05.08 Formulary Transition Fill Process

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

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

- are non-formulary; or
- are formulary and require prior authorization or step therapy under a Plan's utilization management rules; or
- have quantity limits or daily dose limits that are not safety related.

TF-eligible claims will process and pay upon initial submission and messages will indicate when claims have paid under TF rules. Providers do not need to resubmit a TF prior authorization code for TF-eligible claims to adjudicate upon initial submission. The messages listed below will return with paid TF claims so Providers can remind Part D Enrollees of actions that should be taken to ensure access to products in accordance with Part D formularies and benefits. Provider will receive one of the following messages with the paid claim under TF rules:

<<Paid under Transition Fill - Non-formulary>>

<<Paid under Transition Fill - PA required>>

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

The following products are not TF eligible:

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

For submitted claims not eligible for TF,

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

is intended to remind Providers to provide the required Part D Notice of Appeal Rights directly to Part D Enrollees should they want to appeal rejected claims with Part D Plans. Notice must be given directly to Part D Enrollees any time this reject occurs on a claim. Refer to section **10.01.08 CMS-10147 Pharmacy Notice** of the Provider Manual.

The Transition Supply is an approved month's supply for both the outpatient and the long-term care patient.

Outpatient Transition Fill

Transition Fill Condition	Description	Allowed TF Supply for the Retail Setting
Part D Enrollee who is newly enrolled in Plan	• Transition of a new Part D Enrollee following the annual enrollment period or special enrollment period • Transition of newly eligible Part D Enrollee from other coverage • Transition of Part D Enrollee switching from one Plan to another after start of contract year	• Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage in the new Plan
Renewing Part D Enrollee across Plan contract years	• Renewing Part D Enrollee impacted by negative formulary change across Plan contract years and has history of utilization of impacted drug within the look-back period (established by the Plan) from date of claim and previous claim not TF for the same reason • If Part D Enrollee has not transitioned before beginning of new contract year	• Dispense drugs with a first fill of a maximum of an approved month's supply, or less if the prescription is written for fewer days • Prescriptions are allowed to have refills that accumulate to at least an approved month's supply within at least the first 90 days of coverage effective at the beginning of the new contract year
Part D Enrollee requesting exception and decision still pending	Part D Enrollee requesting exception and decision still pending by either end of TF period, or allowed TF days' supply exhausted	Contact the Pharmacy Help Desk for transition extension overrides under this condition

For questions, concerns or issues related to transition fill claim processing, refer to section **10.02.02 Medicare Part D Calls to the Pharmacy Help Desk** of the Provider Manual for the appropriate telephone number to call.

10.05.09 Insulin Coverage

Medicare Part B covers durable medical equipment (DME) and drugs delivered via DME devices at home, including insulin pumps and the insulin they administer. Medicare Part D covers insulin when Part B doesn't apply, specifically insulin delivered through non-durable devices (e.g., syringes, pens, disposable pumps) and related supplies. In Long-Term Care (LTC) settings, Part D also covers all home-use insulin and supplies, plus insulin delivered via DME pumps.

10.05.10 Pro-Rated Daily Cost Share

For applicable Plans with a copayment benefit, Part D Plan Sponsors must establish and apply a daily cost-sharing rate whenever certain Covered Items (depending on the product) are dispensed by Provider for less than the Part D Plan Sponsor's defined 1-month supply in accordance with 42 C.F.R. § 423.153(b)(4)(i).

Caremark will apply a daily cost-sharing rate for a covered Part D drug that is dispensed for less than the Plan-defined 1-month supply. If a claim applies a daily cost-sharing rate Provider may receive the following message:

> **<<023 – Prorated copayment applied based on days supply. Plan has prorated the copayment based on days supply>>**

The daily cost-sharing rate applies if the product (brand or generic) is in the form of a solid oral dose and is dispensed for a days' supply less than the Plan-defined 1-month supply under applicable Law, except for the following types of products:

- Solid oral doses of antibiotics
- Solid oral doses that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist patients with compliance

- Non-Part D products, unless the Part D Plan has specified that copay proration extends to covered products that are treated as non-Part D under their benefit Plans
- Products dispensed by out-of-network providers

10.05.11 Medicare Part B and Medicare Part D Coverage Determinations

For specific rejects addressing (1) products excluded from Part D coverage as mandated by the Medicare Modernization Act; and (2) products that are covered under Medicare Part B for the designated Part D Enrollee, refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

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

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

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A6	This Product/Service May Be Covered Under Part B

Secondary messaging may also be returned. The secondary message is as follows:

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

The reject message will indicate that a prior authorization is required and include the number for initiating a coverage determination. Providers should call this number to initiate the prior authorization.

10.05.12 End Stage Renal Disease Claim Processing

ESRD "Always" Drugs

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

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

Reject Code	Description
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights
75	Prior Authorization Required
A4	This Product May Be Covered Under the Medicare B Bundled Payment to an ESRD Dialysis Facility

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

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

10.05.13 Prescriber Identification for Medicare Part D Claims

For all Medicare Part D claims, accurate Prescriber identification in claims submission is critical as Caremark relies upon the information for claim adjudication, clinical services, Plan Sponsor initiatives, and audits. In addition, CMS requires a valid and active individual Prescriber National Provider Identifier (NPI) on all claims. Failure to submit a valid and active Prescriber NPI will result in a claim reject. Provider must only dispense and bill a Covered Item under a Prescriber that has prescriptive authority under applicable Law. Provider must maintain the DEA number on the prescription hard copy or electronic prescription record for all prescriptions for controlled substances in accordance with applicable Law. It is not acceptable, at any time, to utilize an invalid or inactive NPI, DEA number, or any other number or identifier (e.g., hospital, clinic, or pharmacy identification number) in the Prescriber Identification field (NCPDP field #411-DB) which does not represent an individual Prescriber. Once Caremark communicates back to Provider that the Prescriber ID is invalid, Provider may resubmit with a corrected Type I (Individual) NPI or if Provider confirms the Prescriber ID entered is active and valid, Provider may submit an appropriate Submission Clarification Code (SCC) to bypass the reject. Per CMS,

Part D Plan Sponsors are required to only report Type 1 (Individual) NPIs on PDE records. Type 2 (group/organizational identifier) NPIs are not accepted for Prescribers. Providers must obtain an individual NPI. Any claim submitted with an invalid NPI will reject with the following or similar reject message:

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

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

Reject Code	SCC Value (NCPDP field #420-DK)
A2	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
42	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
43	43 - Prescriber's DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule
44	43 - Prescriber's DEA is active with DEA Authorized Prescriptive Right OR 45 - Prescribers DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule
46	46 - Prescriber's DEA has prescriptive authority for this drug DEA Schedule
56	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated
619	42 - Prescriber ID Submitted is valid and prescribing requirements have been validated

For additional information on identification of a foreign Prescriber, refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

10.05.14 Claims Submission Window for Medicare Part D

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

RXBIN(s)	Address
004336, 610591, 610415	Medicare Part D PO Box 52066 Phoenix, AZ 85072-2066 Medicare Part D LTC PO Box 52419 Phoenix, AZ 85072-2419
610502	Aetna Medicare Part D and LTC PO Box 52446 Phoenix, AZ 85072-2446
020115, 020388	CarelonRx Medicare Part D and LTC Claims Department – Part D Services PO Box 52077 Phoenix, AZ 85072-2077

Refer to section **10.07.02 LTC Pharmacies Timely Claim Submission** of the Provider Manual regarding timely submission of Medicare Part D LTC claims.

10.05.15 Medicare Part D Claim Adjustment

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

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

1. Provider agrees that by accepting payment from Caremark for these amounts assessed against Part D Enrollees, Provider is certifying that:
    a. Provider has not collected or otherwise waived such amounts from such Part D Enrollees or their representatives;
    b. Provider is in fact carrying a debt for the amounts charged to such Part D Enrollee; and
    c. The amounts reimbursed by Caremark are appropriate, owed, and payable.
2. In cases where Part D Enrollees claims are retroactively identified as inappropriate overpayments to Provider, Caremark will adjust Provider for such amounts. Provider is responsible for:
    a. Collecting outstanding Patient Pay Amount balances from Part D Enrollees; and
    b. Accurately debiting and/or crediting Part D Enrollees to help maintain accurate True Out-of-Pocket (TrOOP) balances for these retroactively identified claims.

10.05.16 Medicare Part D Transaction Fees

To the extent permitted by applicable Law, Caremark charges network Providers, and Provider agrees to pay, Medicare Part D transaction fees that represent pharmacy network management services Caremark provides to network Providers for transactions of Medicare Part D paid claims. For Plan Sponsors and Part D Enrollees, transaction fees shall be included at the point of sale and reported on the Medicare Part D Prescription Drug Event (PDE) file as part of the negotiated price. For every paid Medicare Part D claim Provider transmits to Caremark where a transaction fee was applied, Caremark will deduct the transaction fee amount from future amounts payable to Provider.

10.05.17 Medicare Part B 90-Day Transition Period

Effective January 1, 2024, the Center for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) Plans to provide a minimum 90-day transition period for any active course(s) of treatment covered under Part B initiated prior to the member's enrollment in the MA Plan, even if the treatment began with an out-of-network provider. This includes members who are new to the Plan or new to Medicare. The MA or MAPD Plan must not disrupt the active course of treatment (including use of a Part B drug) or require reauthorization for at least ninety (90) days.

For Part B claims, Caremark has developed a Pharmacy Help Desk (PHD)-driven solution for transition-eligible Part B drug claims set up to reject for a prior authorization. Contact the Caremark Pharmacy Help Desk agents who will provide support by responding to inquiries from pharmacies regarding these rejected claims. Please call the number provided in the claim reject messaging.

10.06 Network Participation and Payment

10.06.01 Product Pricing

Notwithstanding anything to the contrary, Caremark utilizes Medi-Span as reference for product prices. Price files are updated every business day. An initial update to the price file occurs on January 1, or the following business day each year. Point-of-service claims are adjudicated, and Provider is reimbursed in accordance with these updates. For product pricing related to drugs covered under the Medicare Drug Price Negotiation Program, refer to section **10.09 Medicare Drug Price Negotiation.**

Provider may access the Pharmacy Portal at **rxservices.cvscaremark.com** to receive advance notice of changes to MAC for Medicare Part D Claims. Refer to section **6.04 Maximum Allowable Cost** of the Provider Manual.

10.06.02 Pharmacy Service Type and Patient Residence Requirements

To ensure appropriate adjudication and reimbursement, Providers must submit valid Pharmacy Service Type and Patient Residence codes on all claims. Approved Part D Pharmacy Service Type (NCPDP field #147-U7) and Patient Residence (NCPDP field #384-4X) codes must be submitted accurately to identify claim type. Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**. Intentional or unintentional misrepresentation of valid Pharmacy Service Type, and/or Patient Residence codes that are not aligned with Provider's Pharmacy Service Type as it relates to the patient, or Patient's residence type is not representative of where the patient is physically residing, or aligned with CMS guidelines, constitutes an invalid use of one or more values and claims may be subject to Chargeback.

CMS Acceptable Codes	
Pharmacy Service Type – NCPDP field #147-U7	01-08 and 99
Patient Residence – NCPDP field #384-4X	00, 01, 03, 04, 06, 09, 11

All Medicare Part D claims submitted with Patient Residence code 03 (Nursing Facility) will apply the CMS Appropriate Dispensing requirements (42 C.F.R. 423.154). Every claim must be submitted with the appropriate SCC regardless of days' supply.

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

Reject U7: <<M/I Pharmacy Service Type>> or

Reject 4X: <<M/I Patient Residence>> respectively.

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

As recommended by NCPDP, Caremark accepts the below values to ensure appropriate adjudication and reimbursement. Provider must be in the specific Medicare Part D network in order to submit these codes and receive appropriate payment. In addition, home infusion and LTC claims must meet the CMS qualifications (e.g., skilled nursing unit) to receive appropriate payment.

Administrative Codes:

- Patient Residence on the claim submission must represent the true and actual residence of the Part D Enrollee; documentation must support the code that was used on the claim.
- Pharmacy Service Type on the claim submission must represent the true and actual service type provided by the pharmacy; documentation must support the code that was used on the claim.

Pharmacy Type	Claim/Service Type	Pharmacy Service Type (Field #147-U7)	Patient Residence (Field #384-4X)
Retail	Retail	01	01
Home Infusion	HIF	03	01
Home Infusion	ALF	03	04
Long-term Care	LTC	05	03
Long-term Care	ICF/IID	05	09
Assisted Living Facility	ALF	05	04

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

10.07 Special Instructions for Participating Long-Term Care Providers

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

10.07.01 Pharmacies Serving LTC Facilities

Prescription Drug Benefit Manual – Section 40.3.1

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

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

If Provider is on site, Provider must deliver the notice to the location in the LTC facility designated to accept such notices. The LTC facility staff is responsible for providing the Part D Enrollee (or the Part D Enrollee's appointed representative) and the Part D Enrollee's treating Prescriber with the notice. A copy of the notice should be placed in the Part D Enrollee's file at the LTC facility (refer to section **10.01.08 CMS-10147 Pharmacy Notice** of the Provider Manual).

10.07.02 LTC Pharmacies Timely Claim Submission

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

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

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

RXBIN(s)	Address
004336, 610591	Long-term Care (LTC) Claims: Attn: Medicare Part D LTC PO Box 52419 Phoenix, AZ 85072-2419
610502	Aetna Long-term Care (LTC) Claims Attn: Aetna Medicare Part D LTC PO Box 14023 Lexington, KY 40512-4023
020115, 020388	CarelonRx Medicare Part D and LTC Claims Department – Part D Services PO Box 52077 Phoenix, AZ 85072-2077

10.07.03 LTC Appropriate Days' Supply Short Cycle Billing

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

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

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

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

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

Three fields have been utilized to accommodate ADS dispensing requirements: Patient Residence code, SCC and Special Packaging Indicator (SPI).

Submission Clarification Code (NCPDP Field #420-DK)	
Code	**Description**
21	LTC dispensing: 14 days or less not applicable (N/A) – 14 days or less dispensing is N/A due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e., vacation supply, leave of absence, e-kit, spitter dose). Medication quantities are dispensed as billed
22	LTC dispensing: 7 days – Pharmacy dispenses medication in 7-days' supply
23	LTC dispensing: 4 days – Pharmacy dispenses medication in 4-days' supply
24	LTC dispensing: 3 days – Pharmacy dispenses medication in 3-days' supply
25	LTC dispensing: 2 days – Pharmacy dispenses medication in 2-days' supply
26	LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1-days' supply
27	LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4-days', then 3-days' supplies
28	LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2-days', then 2-days', then 3-days' supply
29	LTC dispensing: daily and 3-day weekend - Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekends
30	LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes)
31	LTC dispensing: Per med pass dispensing – Remote dispensing per med pass
32	LTC dispensing: PRN on demand – Remote dispensing on demand as needed
33	LTC dispensing: 7 days or less cycle not otherwise represented
34	LTC dispensing: 14 days – Pharmacy dispenses medication in 14-days' supply
35	LTC dispensing: 8-14 days dispensing not listed above – 8-14-days dispensing cycle not otherwise represented
36	LTC dispensing: dispensed outside of short cycle. Medicare Part D coverage was determined post dispensing

Refer to the NCPDP standard at **member.ncpdp.org/Standards-lookup**. Membership to NCPDP is required to view this information online.

10.07.04 LTC Days' Supply Limitations

As per CMS guidance, LTC Providers in the LTC Medicare Part D networks are allowed to dispense at least a 31-days' supply of Covered Items for Part D Enrollees. If a Covered Item being provided is the smallest commercially available package size and exceeds the allowable of at least a 31-days' supply, the quantity may be submitted utilizing the quantity of the single package with the corresponding day supply. Refer to section **10.07.03 LTC Appropriate Days' Supply Short Cycle Billing** of the Provider Manual.

10.07.05 LTC Transition Fill

Qualified claims for LTC Emergency Supply and LTC new patient admission transition fills must be submitted with the appropriate LTC Pharmacy Service Type and Patient Residence codes. See additional information in the table below.

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

*Refer to section **10.07.03 LTC Appropriate Days' Supply Short Cycle Billing** of the Provider Manual for exceptions.

10.07.06 Special Packaging Indicator

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

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

10.07.07 LTC Override Requests

Emergency Supply:

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

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

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

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

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

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

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

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

In addition to circumstances impacting new enrollees who may enter a plan with a medication list that contains non-formulary Part D drugs, other circumstances exist in which unplanned transitions for current enrollees could arise and in which prescribed drug regimens may not be on sponsor formularies. These circumstances usually involve level of care changes in which a beneficiary is changing from one treatment setting to another. For example, beneficiaries who enter LTC facilities from hospitals are sometimes accompanied by a discharge list of medications from the hospital formulary with very short term planning taken into account (often under 8 hours). Similar situations may exist, for example, for beneficiaries who are discharged from a hospital to a home; for beneficiaries who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary; for beneficiaries who give up hospice status to revert to standard Medicare Part A and B benefits; for beneficiaries who end an LTC facility stay and return to the community; and for beneficiaries who are discharged from psychiatric hospitals with drug regimens that are highly individualized.

Utilization Management Rules:

Below are Part D Plan Sponsor's utilization management rules to LTC Part D Enrollees for LTC emergency supplies and LTC admissions/level of care changes.

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

Emergency Supply Situations:

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

*based on Plan design

Qualified claims for LTC Emergency Supply and LTC new patient admission transition fills are submitted with the Pharmacy Service Type (PST) and Patient Residence (PR) that designate LTC.

Submission Clarification Code (NCPDP field #420-DK)		
Code	**Situation**	**Allowances**
07	Emergency Supply (only as defined in this section)	31days' supply
14 (use value 3 for ALF)	Leave of Absence Vacation supply	5-days' supply
15	Patient "Spit Out"	Not applicable
16	Emergency Kit (Emergency Dose)	5-days' supply
17	First Fill Following Emergency Kit Dose	Written Rx Less E.R. Kit Dose given
18	LTC admission/level of care change	Up to 34-days' supply with multiple fills within 31 days of admission or change of care, day supply includes claims where no SCC 18 is used after new admission/level of care change
19	Partial Payment under Medicare Part A	Not applicable

Refer to the applicable payer sheet(s) found online at **caremark.com/pharminfo**.

10.07.08 Medicare Part A and Medicare Part D Drug Coverage Determinations

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

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

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

Reject 75 <<Prior Authorization Required>>

Reject A3 <<This Product May Be Covered Under Hospice – Medicare A>>

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

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

The reject message will direct the pharmacy to the Pharmacy Help Desk. The Pharmacy Help Desk representative will verify if the Part D Enrollee is in hospice and inform Provider that written termination documentation from hospice or Part D Enrollee is required before an override can be placed. If the Part D Enrollee has confirmed with the Provider, and the Provider confirms on the recorded line, that the Part D Enrollee has never been cared for/or resided in hospice care, the Pharmacy Help Desk representative may place a one-time override not to exceed a 12-month period.

IMPORTANT:

1. As specified in the Social Security Act, Section 1861(dd), and Federal Regulations (42 C.F.R. Section 418 *et seq.*), hospice programs must provide individuals under hospice care with drugs and biologicals related to the palliation and management of the terminal illness as defined in the hospice plan of care.
2. Stand-alone prescription drug Plan Sponsors cannot easily identify and prevent Part D payment for hospice drugs. Provider should work with LTC facilities in which their patients reside or hospice providers to identify any Part D Enrollees who have elected hospice care and ensure hospice drugs are not billed to Part D.
3. For those Plan Sponsors utilizing Caremark coverage determination services, if the treatment is unrelated to the terminal condition, the Pharmacy Help Desk will direct the Provider to ask the hospice provider to fax the form to the Coverage Determinations and Appeal Department and provide the written documentation for the Part D

exception. Provider must provide the Pharmacy Help Desk with the hospice provider's contact information to help expedite the process. Caremark's prior authorization department will handle the documentation requests and inform Provider if an approval will be made.

4. For Part D Plan Sponsors not utilizing Caremark for coverage determinations, the telephone number in the message will direct Provider to the Part D Plan Sponsor's coverage determination department to initiate the process.
5. Per CMS guidance, for Part D Enrollees and/or caregivers who state they are no longer in hospice, Caremark requires written documentation prior to overriding the hospice reject. The four acceptable forms are outlined as the Best Available Evidence below. The documentation can be faxed to Caremark at **1-844-242-0904**. Caremark requires a retail and LTC pharmacy to provide the hospice contact information to the Pharmacy Help Desk. Part D Enrollees and/or caregivers may ask Providers to fax the documentation to Caremark.

The following valid documents can be provided as Best Available Evidence of hospice disenrollment or discharge:

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

10.08 Medicare Prescription Payment Plan

On August 16, 2022, H.R. 5376, "Inflation Reduction Act (IRA) of 2022" was signed into law. The IRA law introduced a new program called the Medicare Prescription Payment Plan, which went into effect January 1, 2025. The IRA law required Medicare Part D Plans to provide Medicare Part D Enrollees the option to spread Part D out-of-pocket costs out over the remaining months of the plan year to help reduce gaps in care, where paying the full prescription copay at point of service may create patient affordability risks. For Part D Enrollees who opt in, the Medicare Prescription Payment Plan allows Part D Enrollees to make monthly payments to Medicare Part D Plan Sponsors instead of paying the full prescription copay at the pharmacy.

The Medicare Prescription Payment Plan program is not applicable to Indian Health Services, Tribal, and Urban (I/T/U) pharmacy programs. Medicare Prescription Payment Plan claims submitted from an I/T/U pharmacy will reject.

CMS guidance varies by pharmacy type. For more information for Providers visit:

cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan

CMS has also published a fact sheet for Part D Enrollees which can be found at:

medicare.gov/publications/12211-whats-the-medicare-prescription-payment-plan.pdf (this document can be provided to Part D Enrollees)

10.08.01 Payments

- Part D Enrollees that opt in to the program will pay $0 at the pharmacy but are still responsible for the cost-sharing for their prescriptions.
- Part D Enrollees will receive a monthly bill from their Plan Sponsor.
- Prescription copay amounts the Part D Enrollee would have paid at the point-of-sale to the pharmacy will be paid by the Medicare Part D Plan Sponsor to the pharmacy.

10.08.02 Claims

All eligible Part D products must be submitted in compliance with the Medicare Prescription Payment Plan program requirements until the Part D Enrollee reaches the out-of-pocket (OOP) threshold or opts out of the program. Providers must provide the Likely-to-Benefit notice, submit Medicare Prescription Payment Plan claims, and respond to claim messages as described below.

Scenario	Way to Identify	Information or Pharmacy Actions
1	Approved message code **Ø56** returned on claim response	If a Part D Enrollee's OOP costs on a single claim amount to $600 or greater, and Part D Enrollee has not opted in, "056" (Beneficiary likely to benefit from Medicare Prescription Payment Plan) is returned in NCPDP field #548-6F, indicating you are required to deliver the Likely-to-Benefit Notice. • The pharmacy does not enroll the Part D Enrollee; the Part D Enrollee must opt in with their Part D Plan Sponsor. • The final CMS-published Likely-to-Benefit Notice* materials are available for download: **cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan**
2	Approved message code **Ø57** returned on claim response	If a Part D Enrollee has opted in, "057" (Beneficiary participating in Medicare Prescription Payment Plan) is returned in NCPDP field #548-6F. • Coverage details will be returned within the last payer occurrence in the Other Payer segment of the Part D claim response. • When Part D Enrollee has opted in, claim should be submitted through the current NCPDP COB process to Medicare Prescription Payment Plan. • Review Appendix C of the updated "Supplemental to Medicare Part D Other Payer Patient Responsibility (OPPR)" payer sheet which contains new Medicare Prescription Payment Plan details published at: **caremark.com/portal/asset/D0PayerSheetMEDDOPPR.pdf**
3	Approved message code **Ø58** returned on claim response	If a Part D Enrollee is no longer participating, "058" (Beneficiary is no longer a participant in the Medicare Prescription Payment Plan due to voluntary or involuntary termination) is returned in NCPDP field #548-6F. • A Likely-to-Benefit Notice does not need to be delivered. • A Medicare Prescription Payment Plan COB claim is not needed.
4	If a Part D Enrollee has not elected to participate and never reaches a $600 OOP threshold on a single claim, no claim messaging is returned and no action is required, related to the Medicare Prescription Payment Plan.	

***Likely-to-Benefit Notices**

- Depending on your pharmacy type, you may have specific Likely-to-Benefit Notice delivery instructions. The final CMS-published Likely-to-Benefit Notice materials are available for download. Refer to "Medicare Prescription Payment Plan Final Part Two Guidance" dated July 16, 2024: **cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan**
- You will be required to provide the Medicare Prescription Payment Plan Likely-to-Benefit Notices when Medicare Part D claim response instructs you to do so through use of approved message code "056" (in NCPDP field #548-6F).

10.08.03 Coordination of Benefits

CMS requires the use of the National Council for Prescription Drug Programs' (NCPDP) coordination of benefits (COB) billing for Medicare Prescription Payment Plan processing. The Medicare Prescription Payment Plan coverage details will be returned within the last payer occurrence in the Other Payer segment of the Part D claim response. The Medicare Prescription Payment Plan must use Other Payer-Patient Responsibility (OPPR) COB processing and can only be applied when there is a paid Medicare Part D claim with a copay higher than $0; therefore, Medicare Prescription Payment Plan COB processing only supports Other Coverage Code (OCC) of "Ø8" (OCC "Ø 2", "Ø 3", and "Ø 4" will never be allowed). The pharmacy will be responsible for submitting the Medicare Prescription Payment Plan COB claim to Caremark as the last payer, after any other primary or supplemental coverages have been billed (e.g., Medicare Secondary Payer [MSP] scenarios, Other Health Insurance [OHI] coverages). Review Appendix C of the updated "Supplemental to Medicare Part D Other Payer Patient Responsibility (OPPR)" payer sheet which contains new Medicare Prescription Payment Plan details published at:

www.caremark.com/portal/asset/D0PayerSheetMEDDOPPR.pdf

10.09 Medicare Drug Price Negotiation

Under the Medicare Drug Negotiation Program ("Negotiation Program") established by the Inflation Reduction Act of 2022 (P.L. 117-169), the Centers for Medicare & Medicaid Services ("CMS") is required to negotiate the maximum fair

price (MFP) for certain high expenditure, single source drugs (known as "selected drugs") under Medicare Part D with the manufacturers of these drugs. Under the Negotiation Program, participating manufacturers must provide access to the MFP for a selected drug not only to MFP-eligible individuals but also to pharmacies and other dispensing entities that dispense the selected drug to an MFP-eligible individual during the timeframe that the selected drug has an MFP (known as "a price applicability period"). The first price applicability period is the 2026 plan year.

A manufacturer must provide access to the MFP in one of two ways: (1) prospectively ensuring that the price paid by the dispensing entity when acquiring the drug is no greater than the MFP; or (2) retrospectively providing reimbursement for the difference between the dispensing entity's acquisition cost and the MFP.

To ensure MFP-eligible individuals have access to MFPs at point of sale, Caremark, on behalf of its Part D Plan Sponsors must reimburse Part D claims for selected drugs at an amount no greater than the MFP plus the applicable Dispensing Fee. Accordingly, for purposes of section **6.02 Provider Payment** of the Provider Manual, Provider will be reimbursed an amount no more than the applicable MFP plus applicable Dispensing Fee less the applicable Patient Pay Amount for all Medicare claims for selected drugs dispensed to Eligible Persons who are MFP-eligible individuals. Section 4.3 or Schedule A, whichever is applicable, of the Provider Agreement is amended to add "(vii) the Medicare Drug Price Negotiation Program Maximum Fair Price plus applicable Dispensing Fee less the applicable Patient Pay Amount if applicable to an MFP-eligible Individual."

CMS has engaged a contractor, the Medicare Transaction Facilitator (MTF), to facilitate the exchange of data and payment between manufacturers and dispensing entities and to support the verification that the selected drug was dispensed to an MFP-eligible individual. This will be accomplished through two distinct modules, the MTF Data Module (MTF DM) and the MTF Payment Module (MTF PM). Additional information about the MTF and its processes is available directly from the CMS website:

cms.gov/priorities/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program

For the 2026 plan year and all subsequent years for which Provider is contracted with Caremark to provide services to Eligible Persons under Part D, in accordance with CMS requirements, Provider is required (1) to be enrolled in the MTF Data Module (or any successor to the MTF DM) as specified by CMS; and (2) maintain and certify to CMS that the enrollment information provided in the MTF DM is accurate, complete, and up to date, pursuant to applicable terms and conditions of participation with the MTF DM, as specified by CMS, including, but not limited to, contact, third-party support entity or entities, and banking information, as specified by CMS, and (3) attest to Caremark that they are enrolled in the MTF DM and that the enrollment information provided in the MTF DM is accurate, complete and up to date, pursuant to applicable terms and conditions of participation with the MTF DM.

10.10 Retail Addendum to the Caremark Provider Agreement

Terms of Participation in Medicare Part D

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

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

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

1. Provider agrees to participate as, and perform the functions of, a Part D Retail Dispensing Pharmacy, including any reporting functions required to Part D Plan Sponsors, in accordance with the terms and conditions set forth in this Retail Addendum.
2. Provider agrees to perform its services under this Retail Addendum in a manner that is consistent with, and encompasses the services required to support Part D and in compliance with the contractual obligations of a Part D Plan Sponsor to CMS.
3. Provider agrees not to hold any Part D Enrollee liable for payment of any fees that are the responsibility of Caremark or a Part D Plan Sponsor.

4. Provider and Caremark agree that Provider is not required to accept Insurance Risk as a condition of participation as a Dispensing Pharmacy for Part D, and in the Medicare Part D Retail Network.
5. Provider agrees to comply with all applicable federal and state laws and regulations, CMS guidance or instructions relating to Part D, and any minimum standards for Provider practice established by the States in which Provider is licensed. Provider agrees to comply with all applicable state and federal privacy and security requirements, including the confidentiality and security requirements set forth in 42 C.F.R. § 423.136, the Privacy Rule, Security Rule, and Transactions Standards.
6. Provider agrees to make its books and records available in accordance with, and for the period required by 42 C.F.R. § 423.505(i)(2), which gives HHS, the Comptroller General, or their designees (collectively, "Government Parties"), the right to audit, evaluate, collect, and inspect any books, contracts, records, computers, or other electronic systems, including medical records, and documentation of Provider involving transactions related to CMS' contract with a Part D Plan Sponsor (collectively, "Records"), and that these rights continue for a period of ten (10) years from the termination date of the Provider Agreement, ten (10) years after the final date of any Part D Plan Sponsor's contract with CMS to offer a Medicare Part D Plan, or ten (10) years after the date of completion of any CMS audit of a Part D Plan Sponsor, whichever is later; provided that Provider must maintain its prescription records in their original format for the period required by applicable state Law, if any, but may, subject to applicable CMS guidance, then transfer such prescription records to an electronic format that replicates the original prescription for the remaining years of the ten (10) year retention period. In the case of a request by a Government Party for the direct disclosure by Provider to the Government Party of Records, Provider shall (a) provide Caremark with prompt written notice of the Government Party's request so that Caremark can object or intervene as it deems proper; (b) take all appropriate steps to protect the confidentiality of the Records, including labeling it "CONFIDENTIAL AND PROPRIETARY – FOIA EXEMPT" and attaching a statement provided by Caremark explaining the application to the Records of any Freedom of Information Act or other exemptions to disclosure; and (c) provide Caremark with the opportunity to review the Records that is subject to disclosure to the Government Party prior to Provider's release of same to the Government Party. Provider also agrees to maintain records and provide access in accordance with 42 C.F.R. § 423.505(b)(10).
7. Provider agrees that, upon a Part D Plan Sponsor delegating any activity or responsibility to Caremark and Caremark in turn delegating that activity or responsibility to Provider pursuant to this Retail Addendum, that activity or responsibility may be revoked if CMS, the Part D Plan Sponsor, or Caremark determines that Provider has not performed satisfactorily. CMS, the Part D Plan Sponsor, or Caremark may also exercise any remedies available at Law or under the Provider Agreement in lieu of revocation. Further, Provider agrees that such activity or responsibility shall be in accordance with 42 C.F.R. § 423.505(i)(3).
8. Provider agrees that Caremark and any Part D Plan Sponsor (with respect to its Part D Enrollees only) each has the right to approve, suspend, or terminate the Provider Agreement in their sole discretion at any time.
9. Provider agrees that Caremark and the Part D Plan Sponsor will monitor the performance of Provider on an ongoing basis.
10. Provider agrees to provide Part D Enrollees with access to Negotiated Prices for covered Part D drugs as required by and in accordance with 42 C.F.R. § 423.104(g).
11. Provider agrees to submit Claims to Caremark's real-time claim adjudication system.
12. Provider agrees that when it dispenses a covered Part D drug to a Part D Enrollee, it will inform such Part D Enrollee at the point of sale of the lowest-priced, generically-equivalent version of that covered Part D drug, if one exists for the Part D Enrollee's prescription, as well as any associated differential in price in accordance with 42 C.F.R. § 423.132.
13. Provider agrees to implement a method for maintaining up-to-date Part D Enrollee information including, but not limited to, demographic and allergy (drug) information, and such other information as CMS may require.
14. Provider agrees to implement such utilization management and quality assurance programs, including concurrent drug utilization review, generic substitution and/or therapeutic interchange programs, as Caremark may require, and as consistent with and in compliance with 42 C.F.R. § 423.153(b), (c) and (d). Provider agrees to offer patient counseling to Part D Enrollees, where appropriate and/or required by Law.
15. Provider agrees to fill a prescription for a 90-day supply of covered Part D drugs for Part D Enrollees at the appropriate cost-sharing and Negotiated Price as communicated by Caremark to Provider through the real-time claim adjudication process, including that which applies to individuals qualifying for the low-income subsidy.
16. Provider agrees to charge/apply the correct cost-sharing amount, including that which applies to individuals qualifying for the low-income subsidy.
17. Part D Claims may be priced using the Provider Agreement, the Caremark Medicare Part D Retail Network, or other Caremark or Plan Sponsor-specific network.

18. Provider agrees to accept Part D Enrollees for inclusion in Plan Sponsor established drug management programs. The Plan Sponsor or its delegate, consistent with the requirements of 42 CFR Section 423.153, shall notify Provider of Provider's selection as the exclusive Provider for designated Covered Items for the Part D Enrollee.
19. Provider acknowledges that it is not a mail order pharmacy and it is a "retail pharmacy" as defined in 42 C.F.R. § 423.100.
20. Entire Agreement. This Retail Addendum, the Provider Agreement, the Provider Manual, and the Medicare network enrollment form, and all other applicable enrollment forms, constitute the entire agreement between Provider and Caremark for the purposes of Provider's participation as a Medicare Part D network Provider, all of which are incorporated by this reference as if fully set forth herein and referred to collectively as the "Provider Agreement" or "Agreement". Any prior agreements, promises, negotiations, or representations related to the terms of this Retail Addendum are terminated and of no force and effect. Provider's non-compliance with any of the provisions of this Retail Addendum will be a breach of the Provider Agreement. All pricing terms are considered to be Caremark's confidential and proprietary information and may not be shared with any third party without express written consent from Caremark.
21. The following terms and phrases, when capitalized and when used in this Retail Addendum, have the meanings set forth below. All other capitalized terms and conditions shall have the meaning set forth in the Provider Agreement.
    a. "Claims" means those claims processed through the Caremark online, real-time claim adjudication system.
    b. "CMS" means the Centers for Medicare & Medicaid Services under the Department of Health and Human Services.
    c. "Covered Part D drug(s)" has the same meaning as that term as defined in 42 C.F.R. § 423.100.ß.
    d. "Dispensing Fee" has the same meaning as such term is defined in 42 C.F.R. § 423.100 which states that dispensing fee means costs that are incurred at the point of sale and pay for costs in excess of the ingredient cost of a covered Part D drug each time a covered Part D drug is dispensed, and includes only pharmacy costs associated with ensuring the possession of the appropriate covered Part D drug is transferred to a Part D Enrollee.
    e. "HHS" means the Department of Health and Human Services.
    f. "Insurance Risk" has the same meaning as such term as defined in 42 C.F.R. § 423.4.
    g. "Medicare Part D Retail Network" means Claims priced for a Part D Enrollee pursuant to the Retail Addendum to the Caremark Provider Agreement entitled "Caremark Medicare Part D Retail Pharmacy Network."
    h. "Negotiated Prices" has the same meaning as such terms as defined 42 C.F.R. § 423.100.
    i. "Part D" means Part D of Title XVIII of the Social Security Act, which establishes the Voluntary Prescription Drug Benefit Program under Medicare.
    j. "Part D Enrollee" means an individual covered by a Part D Plan.
    k. "Part D Plan" has the same meaning as such term as defined in § 423.4, but limited to those Part D Plans that have contracted with SilverScript, L.L.C. to use pharmacy providers that have contracted with Caremark to provide Pharmacy Services to Part D Enrollees.
    l. "Part D Plan Sponsor" has the same meaning as such term as defined in 42 C.F.R. § 423.4, but limited to those Part D Plan Sponsors that offer Part D Plans.
    m. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.
    n. "Security Rule" shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. parts 160, 162 and 164, subpart C. Notwithstanding anything to the contrary in the Agreement, any requirements related to the Security Rule shall be effective no earlier than the applicable Compliance Date for the Security Rule.
    o. "Transactions Standard" means the Standards for Electronic Transactions under 45 C.F.R. parts 160 and 162, subparts I et.seq.

11. Medicare Advantage

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

1. The Department of Health and Human Services, the Comptroller General or their designees have the right to audit, evaluate, collect, and inspect any pertinent information including books, contracts, computer or other electronic systems, including medical records, and documentation related to CMS' contract with Plan Sponsor for a period of ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. 42 C.F.R. 422.504(i) (2)(i)-(ii) and (iv).
2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including, but not limited to, (a) abiding by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, (b) ensuring that medical information is released only in accordance with applicable federal or state law or pursuant to court orders or subpoenas, (c) maintaining the records and information in an accurate and timely manner, and (d) ensuring timely access by Part D Enrollees to the records and information that pertain to them, including 42 C.F.R. 422.118; 42 C.F.R. 422.504(a)(13).
3. Provider may not hold an Eligible Person liable for payment of fees that are the legal obligation of the Plan Sponsor to fulfill. Such provision will apply to, but will not be limited to, insolvency of Caremark or Plan Sponsor, contract breach, and Provider billing. 42 C.F.R. 422.504(g)(1)(i); 422.504(i)(3)(i); MMA Manual Chapter 11, Section 100.
4. Any services performed in accordance with a contract are consistent and comply with the Plan Sponsor's contractual obligations to CMS. 42 C.F.R. 422.504(i)(3)(iii).
5. Provider will be paid in compliance with the requirements of 42 C.F.R. 422.520(b).
6. Caremark and Plan Sponsor may approve, suspend, or terminate the Provider Agreement with respect to Provider's provision of Pharmacy Services for a Medicare Advantage Plan Sponsor. 42 C.F.R. 422.504(i)(5).
7. Caremark and Plan Sponsor have the right to revoke the Provider Agreement with respect to delegated activities performed or to seek other remedies in lieu of termination as provided in the Provider Agreement if Caremark, CMS, or the Plan Sponsor determines that Provider has not performed its obligations satisfactorily. Caremark and Plan Sponsor will monitor Provider's performance hereunder on an ongoing basis. 42 C.F.R. 422.504(i)(4)(ii) and (iii).
8. Caremark and Plan Sponsor will review the credentials of medical professionals affiliated with Provider. Caremark and Plan Sponsor will also review and approve the credentialing process, including audits of the credentialing process on an ongoing basis. 42 C.F.R. 422.504(i)(4)(iv).
9. Provider must comply with applicable Medicare laws and regulations and CMS instructions and to allow audits and inspection by CMS and/or its designees and must cooperate, assist, and provide information as requested, and maintain records a minimum of ten (10) years from the final date of the Medicare Advantage Plan Sponsor's contract period with CMS or from the date of completion of any CMS audit, whichever is later. 42 C.F.R. 422.504(i) (4)(v) and MMA Manual, Chapter 11, Section 100.4.
10. Provider agrees that Caremark and Plan Sponsor oversee Provider and are accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations. MMA Manual, Chapter 11, Section 100.4.
11. Provider must not discriminate in the furnishing of benefits on the basis of any factor that is related to health status including, but not limited to, (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (g) disability. 42 C.F.R. 422.110(a).
12. Provider must comply with the Plan Sponsor's policies and procedures and written standards, which in accordance with 42 C.F.R. 422.112(a)(6) require:
    a. Timely access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services are continuously monitored to ensure compliance and that Caremark and Plan Sponsor will take corrective action as necessary;
    b. Compliance with the Plan Sponsor's coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations; and
    c. Provider consideration of Part D Enrollee's input into Provider's proposed treatment plan.

13. Provider must ensure that its Pharmacy Services are available 24 hours a day, 7 days a week, when medically necessary. 42 C.F.R. 422.112(a)(7)(ii).
14. Provider must provide its Pharmacy Services in a culturally competent manner to all Eligible Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. 42 C.F.R. 422.112(a)(8).
15. Provider must provide effective and continuous patient care and quality review and maintain health records in accordance with standards established by the Plan Sponsor, taking into account professional standards and that there is appropriate and confidential exchange of information with other network Providers. 42 C.F.R. 422.112(b)(4)(ii)-(iii).
16. Provider must establish procedures to ensure that Eligible Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health, and systems to address barriers to Eligible Person compliance. 42 C.F.R. 422.112(b)(5) and (6).
17. Nothing in the Provider Agreement shall be construed as requiring Provider to indemnify Caremark or Plan Sponsor against any civil liability for damage caused to an Eligible Person as a result of a Plan Sponsor's denial of medically necessary care to such Eligible Person. 42 C.F.R. 422.212.

12. Qualified Health Plans

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

1. To comply with all applicable federal and state laws, regulations, and the Department of Health and Human Services ("HHS") guidance, including related to Exchanges, as well as Exchange processes, procedures, and standards in accordance with 45 CFR Part 155 subparts H and K and, in the small group market, 45 CFR §§ 155.705 and 706 if applicable to the Exchange type in which the QHP issuer is operating, including, but not limited to, 45 C.F.R. 156.340(a), to the extent relevant to the Pharmacy Services provided.
2. To permit access by HHS and the Office of Inspector General ("OIG"), the relevant Exchange authority or other applicable regulatory body or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations in accordance with 45 C.F.R. 156.340(a), until ten (10) years after the final date of the Provider Agreement period.
3. For purposes of clarity, delegated activities and reporting responsibilities referenced in 45 C.F.R. 156.340(b), are those Pharmacy Services, if any, specified in the Provider Agreement that are performed for or with respect to the QHP issuer and/or the QHP Eligible Persons.
4. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.
5. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer or Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.
6. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

For QHP Eligible Persons eligible for health benefits under a QHP offered by a QHP Issuer participating in Exchanges that do not use the Federal platform, including on State Exchange SHOPs (Small Business Health Options Programs) and State-based Exchanges. Provider agrees:

1. To comply with all applicable federal and state laws, regulations, and guidance issued by HHS, a State-based Exchange or other applicable regulatory body, including Exchange processes, procedures and standards in accordance with 45 CFR Part 155, subparts H and K and, in the small group market, 45 CFR 155.705 and 706, unless the standard is specifically applicable to a Federally-facilitated Exchange or Federally-facilitated-SHOP, to the extent relevant to the Pharmacy Services provided.
2. To perform Pharmacy Services in a manner consistent with and in compliance with the QHP Issuer's contractual obligations to the State-based Exchange or other applicable regulatory body.
3. To permit access by HHS, the OIG, the State-based Exchange or other applicable regulatory body, or their designees, in connection with those entities' right to evaluate through audit, inspection, or other means, to the downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP Issuer's obligations until ten (10) years after the final date of the Provider Agreement period.
4. For purposes of clarity, delegated activities and reporting responsibilities, referenced in 45 CFR 156.340, are those Pharmacy Services, if any, specified in the Provider Agreement that are performed for or with respect to QHP Eligible Persons.
5. If Provider, as part of its Pharmacy Services, selects other providers, Caremark retains the right to approve, suspend, or terminate such arrangement.
6. Pharmacy Services or delegated activities and reporting responsibilities may be revoked if HHS, the QHP Issuer, State-based Exchange, applicable regulatory body, Caremark, or their designees, determines that Provider has not performed Pharmacy Services satisfactorily. Alternately, in such event, Caremark, in its sole discretion, may pursue remedies in lieu of revocation consistent with the terms of the Provider Agreement.
7. Caremark will monitor Provider's performance of its Pharmacy Services on an ongoing basis and may impose corrective actions as necessary.

13. Intellectual Property, Confidentiality and Proprietary Rights

13.01 Advertising and Trademarks

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

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

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

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

13.02 Non-Disparagement

Provider and/or its agents, including outside counsel acting on its behalf, may not place in a false light, disparage, defame, nor make any damaging, derogatory, or unfavorable public statements regarding Caremark, Caremark's products, programs, services, employees, personnel, and brands in any manner. Provider will provide appropriate and adequate training to ensure compliance with these requirements. Provider's obligations hereunder shall survive termination of the Provider Agreement. Nothing herein shall be construed to prohibit Provider from communicating with elected officials or a government agency.

13.03 Confidentiality

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

Provider and/or its agents, including outside counsel acting on its behalf, must maintain in confidence and may not disclose, sell, assign, transfer, or give to any third party, including a Plan Sponsor or Eligible Person, Confidential Caremark Information without Caremark's prior written consent, unless otherwise permitted by applicable Law. Provider may use Confidential Caremark Information only for the purpose of carrying out its obligations under the Provider Agreement. Provider may disclose Confidential Caremark Information to its employees, agents, consultants, or authorized representatives who have a bona-fide need to know the Confidential Caremark Information in order to carry out Provider's obligations under the Provider Agreement and who (1) have been informed of the confidential and proprietary nature of the Confidential Caremark Information, and (2) have agreed in writing not to disclose the Confidential Caremark Information to others and to treat the Confidential Caremark Information in accordance with the requirements of this section. In doing so, Provider agrees that any of its representatives including, but not limited to, its employees, agents, consultants, or authorized representatives (e.g., legal counsel, business associates, third-party representatives) are bound by the same confidential provisions; non-compliance to this provision can lead up to and include termination of Provider. Provider must provide Caremark a copy of any signed written non-disclosure agreement within five (5) business days of Caremark's written request to Provider.

Provider agrees to protect the security of Confidential Caremark Information and to ensure that it is used and disclosed only as permitted herein. Provider must notify Caremark in writing within five (5) business day after it becomes aware of any unauthorized use of Confidential Caremark Information. Provider is responsible to Caremark for any breach of this section by its employees, agents, consultants, or authorized representatives, including outside counsel acting on its behalf.

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

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

Such notice to Caremark must also be addressed and delivered to:

CVS Caremark
Attn: General Counsel, MC 035
9501 East Shea Boulevard
Scottsdale, AZ 85260

No Confidential Caremark Information may be quoted or attributed to Provider or Caremark without the prior written consent of Caremark.

Provider agrees to protect the confidentiality and security of an Eligible Person's personal information (which includes any information that identifies or can be used to identify an Eligible Person), as required by applicable Law, and to use and disclose such information only as permitted by and in accordance with applicable Law.

This **Confidentiality** section applies to the extent consistent with applicable Law. Where required by Law, Provider is permitted to disclose information related to its reimbursement for a Covered Item to the associated Eligible Person. Nothing herein shall be construed to prohibit Provider from communicating with elected officials or a government agency.

13.04 Non-Solicitation and Non-Interference

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

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

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

13.05 Proprietary Rights

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

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

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

13.06 Remedies

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

Accordingly, if Provider should fail to abide by the provision and terms set forth in chapter **13. Intellectual Property, Confidentiality and Proprietary Rights** of the Provider Manual, Caremark will be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Provider Agreement, and to judgment for damages (including reasonable attorneys' fees and costs) caused by the breach, and all other remedies provided by the Provider Agreement and applicable Law, including termination of the Provider Agreement or Provider's participation in any Caremark network or Plan Sponsor network.

14. Miscellaneous

14.01 Assignment

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

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

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

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

14.02 Independent Contractors and Third-Party Beneficiaries

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

Except as otherwise provided for in the Provider Agreement including, but not limited to, the Indemnification section of the Provider Agreement and section **14.09 Arbitration** of the Provider Manual, no term or provision in the Provider Agreement is for the benefit of any person who is not a party to the Provider Agreement and no such party shall have any right or cause of action under the Provider Agreement.

14.03 Court Orders, Subpoenas or Governmental Requests

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

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

14.04 Notices

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

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

Any notice to Caremark must also be addressed and delivered to:

CVS Caremark
Attn: General Counsel, MC 035
9501 East Shea Boulevard
Scottsdale, AZ 85260

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

Notices are deemed received on the date of delivery to the other party when delivered in person (by certified mail, courier, or first-class mail), by email, by fax, by secure electronic message, or when posted via the Pharmacy Portal. If notice is sent by first-class mail, the notice is deemed received on the third business day after the date such notice was mailed. It is Provider's responsibility to promptly notify Caremark of any changes to Provider's contact information including, but not limited to, street address, mailing or check mailing address, phone number, fax number, or email address. Provider's failure to update its contact information with Caremark, or refusal to accept delivery of a notice from Caremark, shall not relieve Provider of any obligations to comply with the information communicated in the notice and may subject Provider to termination at Caremark's sole discretion. Refer to section **2.05.01 Notification of Change in Documentation and Other Information** of the Provider Manual.

Where Caremark has responded to Provider's communication and a subsequent communication from Provider is duplicative of the communication just resolved, additional information must be sent to Caremark to reopen that communication. Once additional information is received, Caremark will research the concerns expressed in the communication.

By participating as a provider in Caremark's networks, Provider acknowledges that it has a prior express business relationship with Caremark and consents to receive fax communications as well as automated messages from Caremark. Refer to section **1.04 Pharmacy Communications** of the Provider Manual.

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

14.05 Termination

14.05.01 Termination for Cause

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

Caremark may immediately terminate the Provider Agreement if:

1. To the extent consistent with applicable Law, Provider makes an assignment for the benefit of creditors, files a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property, or, a proceeding is commenced against Provider or any principal who holds an ownership interest in Provider which will impair its ability to perform under the Provider Agreement, based on Caremark's sole determination.
2. Any court, governmental, or regulatory agency issues to Provider an order to cease and desist from providing Pharmacy Services.
3. (a) There is any change in who holds (directly or indirectly) the ownership interests in Provider or the ownership interests of any pharmacy in which Provider holds an ownership interest; or (b) the right to control the operation of the business of Provider or any pharmacy in which Provider holds an ownership interest is transferred to a third party.
4. A levy, writ of garnishment, attachment, execution, or similar item is served upon Provider and not removed within ten (10) days from the date of service.
5. Caremark reasonably determines that Provider is no longer active.
6. Provider fails to satisfy amounts or other obligations owed to Caremark. Certain remedies may apply, including termination of the Provider Agreement and any other available remedies.
7. Caremark has reason to believe that Provider has engaged in, or is engaging in, any activity which:
    a. Appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or the general public;
    b. Implies a failure to maintain proper licensure and related requirements for licensure;
    c. Otherwise impairs Provider's ability to fulfill the requirements of the Provider Agreement;

d. Is a breach of the Provider Agreement. Caremark's ultimate remedies under this section include immediate termination of the Provider Agreement, including termination of pharmacies found to have a direct or indirect relationship with Provider or its affiliates based upon common officers, directors, Pharmacists-in-Charge/ responsible pharmacist, managing employees, current/former employees, owners (direct or indirect); or

e. Constitutes fraud, waste or abuse.

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

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

14.05.02 Termination Without Cause

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

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

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

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

14.05.03 Rights and Remedies in the Event of Termination or Breach

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

In the event Provider breaches any provision of the Provider Agreement or fails, subsequent to Caremark's written demand to surrender the Provider Agreement, Provider Manual, other Caremark Documents, or other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control, in addition to all other termination rights, Caremark shall have the right, to the extent not contrary to Law, to (1) suspend any and all obligations of Caremark, including payment to Provider, under and in connection with the Provider Agreement, (2) impose reasonable handling, investigation and/or improper use fees, and/or (3) in whole or in part, offset against any amounts owed to Provider under the Provider Agreement or under any other agreement between Caremark and Provider, any amounts required to be paid by Provider to Caremark. These rights and remedies are not exclusive and are in addition to any other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

14.06 Survival of Certain Provisions

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

14.07 Amendments

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

14.08 Enforceability

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

14.09 Arbitration

Any dispute, claim, or controversy between Provider and Caremark [including Caremark's current, future, or former employees, parents, subsidiaries, affiliates, agents, and assignees (collectively referred to in this **Arbitration** section as "Caremark") including, but not limited to, disputes in connection with, arising out of, or relating in any way to, the Provider Agreement or to Provider's participation in one or more Caremark networks or exclusion from any Caremark networks, including any disputes regarding the interpretation, validity, scope, or applicability of this agreement to arbitrate, will be exclusively settled by arbitration. This arbitration provision applies to any dispute arising from events that occurred before, on, or after the effective date of this Provider Manual. Any dispute otherwise arbitrable hereunder shall be deemed waived, and no such dispute shall be made or raised unless a Dispute Notice has been given to Caremark or Provider, or arbitration filed, as provided below. Unless otherwise agreed to in writing by the parties, the arbitration shall be administered by JAMS pursuant to its then applicable Comprehensive Arbitration Rules and Procedures ("JAMS Rules") including the rule governing Emergency Relief Procedures (available from JAMS). For purposes of clarity, any arbitration initiated shall be administered by JAMS regardless of whether a Dispute Notice was issued before that date. If any provision of this Provider Manual conflicts with any provision of the JAMS Rules, the Provider Manual's provision shall control.

In no event may the arbitrator(s) award indirect, consequential, or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, or damages based on injury to reputation, or loss of customers or business, except as required by Law.

The arbitrator(s) shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of the agreement to arbitrate including, but not limited to, any claim that all or part of the agreement to arbitrate is void or voidable for any reason. The arbitrator(s) must follow the rule of Law, and the award of the arbitrator(s) will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. Any such arbitration must be conducted in Scottsdale, Arizona and Provider agrees to such jurisdiction, unless otherwise agreed to by the parties in writing or as otherwise required by applicable Law. The arbitrator(s) may construe or interpret the agreement to arbitrate but shall not ignore any term of this Provider Manual and shall be bound by controlling law.

In arbitrations where a dispute, claim, controversy, or counterclaim involves at least $1 million, and the parties are unable to agree upon the number of arbitrators, a panel of three arbitrators rather than a single arbitrator shall hear and determine the case. If the parties are unable to agree on the number of arbitrators and the disputes, claims, controversies, or counterclaims involve less than $1 million, one arbitrator shall hear and determine the case. If during the course of the arbitration, the amount in controversy changes or is amended to exceed $1 million, a single arbitrator shall not have authority to conduct a hearing on the merits or issue an award until a panel of three arbitrators is appointed.

If the arbitration is to be conducted by a single arbitrator, the arbitrator must be a retired judge. If the arbitration is to be conducted by a panel of three arbitrators, then (1) one of the arbitrators must be a retired judge, and (2) the chair must be a retired judge or previously have served as chair or single arbitrator in at least ten (10) arbitrations where an award was rendered following a hearing on the merits.

The parties hereby agree that in any underlying award issued by a panel of three arbitrators, as opposed to a single arbitrator, the JAMS Optional Arbitration Appeal Procedures ("Appellate Procedures") shall apply and either party may invoke those appeal procedures. The underlying award shall not be considered final until after the time for filing the notice of appeal pursuant to the Appellate Procedures has expired. Appeals must be initiated within fourteen (14) days after an award has become final, as set forth in the Appellate Procedures, by filing a Notice of Appeal with the JAMS Case Manager and on the opposing party(ies).

Section **14.09 Arbitration** of the Provider Manual and its applicable subsections are applicable to any final awards issued by the appellate tribunal.

14.09.01 Discovery Limitations

Discovery shall be limited to documents and information for which there is a direct, substantial, and demonstrable need, and where such documents and information can be located and produced at a cost that is reasonable in the context of all surrounding facts and circumstances.

Document requests shall (1) be limited to documents that are directly relevant to the matters in dispute or to its outcome; (2) be reasonably restricted in terms of timeframe, subject matter, and persons or entities to which the requests pertain; and (3) not include broad phraseology such as "all documents directly or indirectly related to." Requests shall not be encumbered with extensive "definitions" or "instructions." The arbitrator may edit or limit the number of requests.

E-discovery shall be limited as follows: (1) there shall be production of electronic documents only from sources used in the ordinary course of business. Absent a showing of compelling need, no such documents are required to be produced from backup servers, tapes, or other media; (2) absent a showing of compelling need, the production of electronic documents shall normally be made on the basis of generally available technology in a searchable format that is usable by the requesting party and convenient and economical for the producing party. Absent a showing of compelling need, the parties need not produce metadata, with the exception of header fields for email correspondence; (3) the description of custodians from whom electronic documents may be collected should be narrowly tailored to include only those individuals whose electronic documents may reasonably be expected to contain evidence that is material to the dispute; and (4) where the costs and burdens of e-discovery are disproportionate to the nature of the dispute or to the amount in controversy, or to the relevance of the materials requested, the arbitrator may either deny such requests or order disclosure on the condition that the requesting party advance the reasonable cost of production to the other side, subject to the allocation of costs in the final Award.

There shall be no interrogatories or requests to admit absent agreement of the parties.

Each party may take one deposition of an opposing party or of one individual under the control of the opposing party. Each deposition shall be subject to a four-hour time limit. The necessity of additional depositions shall be determined by the arbitrator based upon the reasonable need for the requested information, the availability of other discovery options and the burdensomeness of the request on the opposing parties and the witness.

Discovery shall be limited to the Provider initiating the dispute and no other Provider. Provider expressly agrees not to seek discovery concerning other Providers, disputes, or arbitration matters not involving the Provider at issue. Provider agrees that an arbitrator(s) shall have no authority hereunder to order discovery related to other Providers, disputes, or arbitration matters not involving the Provider at issue. Any attempt by Provider to seek discovery on other Providers, disputes, or arbitration matters shall be deemed a violation of this provision, as well as chapter **13. Intellectual Property, Confidentiality and Proprietary Rights** of the Provider Manual, and subject Provider to the penalties outlined in those provisions.

In the event a party that initiates an action for emergency or interim relief does not prevail and subsequently foregoes a final hearing on the merits, the emergency arbitrator's order shall be deemed as the final award and the emergency arbitrator shall retain jurisdiction for the purposes of awarding the expenses of arbitration, including reasonable attorney's fees, against the party that initiated the request for emergency or interim relief.

14.09.02 Expenses of Arbitration

The expenses of arbitration, including reasonable attorney's fees, will be paid for by the party against whom the final award of the arbitrator(s) is rendered, except as otherwise required by Law.

14.09.03 Anti-Class; Anti-Consolidation of Claims in Arbitration

Arbitration with respect to a dispute is binding and neither Provider nor Caremark will have the right to litigate that dispute through a court. In arbitration, Provider and Caremark will not have the rights that are provided in court, including the right to a trial by judge or jury. All of these rights are waived and disputes must be resolved through arbitration.

No dispute between Provider and Caremark may be pursued or resolved as part of a class action, private attorney general, or other representative action or proceeding (hereafter all included in the term "Class Action"). All disputes are subject to arbitration on an individual basis, not on a class or representative basis, or through any form of consolidated proceedings, and the arbitrator(s) will not resolve Class Action disputes and will not consolidate arbitration proceedings without the express written permission of all parties to the Provider Agreement. Provider and Caremark agree that each may pursue or resolve a dispute against the other only in its individual capacity, and not as a plaintiff or class member in any purported Class Action. Further, disputes with a Provider are limited to a single NCPDP number per arbitration. A Provider may not consolidate or aggregate the claims of multiple NCPDP numbers into a single arbitration. The parties agree that any arbitration ruling by an arbitrator(s) allowing class-action arbitration or requiring a consolidated arbitration (including consolidating multiple NCPDPs into a single proceeding) would be contrary to the parties' intent and such decisions are subject to immediate judicial review.

14.09.04 Confidentiality of Arbitration

Except as may be required by Law, a party, its employees, agents, consultants, authorized representatives, counsel, or arbitrator(s) shall not disclose the existence, content, or results of any dispute or arbitration hereunder without the prior written consent of both parties. In the event a Provider is required by Law to make such a disclosure, Provider shall notify Caremark five (5) business days in advance of such disclosure. Notwithstanding the confidentiality provisions contained herein, Caremark may notify any of its Plan Sponsor clients of any pending arbitration or the results thereof that may impact the Plan Sponsor. That notice may include disclosing the underlying documents in the arbitration, including, but not limited to, the statement of claim and the opinion rendered in the case. Provider acknowledges and agrees that any breach of this provision would cause Caremark immediate and irreparable injury or loss that cannot be fully remediated by monetary damages. Accordingly, if Provider, its agents, counsel, or arbitrator fail to abide by the terms and conditions set forth in this **Arbitration** section of the Provider Manual, Caremark shall be entitled to (a) specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the Provider Agreement, and to judgment for damages (including reasonable attorneys' fees and costs) caused by the breach; (b) an option to void the dispute resolution or arbitration award; and (c) all other legal and equitable remedies available to Caremark, including termination of the Provider Agreement or Provider's participation in any Caremark network or Plan Sponsor network.

14.09.05 No Collateral Estoppel/Precedential Impact of Award

The decision of the arbitrator is final and binding to the claims raised in the arbitration but is neither *res judicata* nor collateral estoppel to any other claim or suit. The decision is conclusive only of the issues in the matter submitted to the arbitrator and only as to the parties to the arbitration. The decision shall not have any precedential impact on any other proceeding.

14.09.06 Waiver of Right to Confirm Award Upon Payment

If a final award is rendered awarding a party monetary damages, the party against whom the final award was rendered shall have thirty (30) days to pay the monetary award. During this 30-day period, the party in whose favor the monetary award was rendered shall not have the right to seek confirmation or enforcement of the award. If the monetary relief in the final award is paid within this 30-day period, the party in whose favor the monetary award was rendered shall have no right to seek confirmation of the final award under the Federal Arbitration Act, 9 U.S.C. §9, nor under any applicable state arbitration Law.

In addition to the foregoing, the parties will use all reasonable efforts to maintain the confidentiality of any petitions they file to confirm, modify, or vacate an arbitration award under Federal Arbitration Act, 9 U.S.C. §§ 9-11. To the extent the parties initiate an action to confirm, modify, or vacate an arbitration award, the parties shall file such a petition under seal. Unless ordered by the court, the parties expressly agree to not take any action to unseal any (1) filings relating to the petition to confirm, modify or vacate the award or (2) filings or documents relating to the underlying arbitration, including the underlying arbitration award.

14.09.07 Dispute Resolution Procedures

Prior to a party initiating an arbitration, such party shall request in writing to the other party ("Dispute Notice") a meeting of authorized representatives of the parties for the purpose of resolving the dispute. An action must be commenced within two (2) years from the date on which the facts giving rise to the dispute first arose. The parties agree that, within fourteen (14) business days after issuance of the Dispute Notice, each party shall designate a representative to participate in dispute resolution discussions which will be held at a mutually acceptable time and place (or by telephone) for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner. If despite the good faith efforts of the parties, the authorized representatives of the parties are unable to resolve the dispute within forty-five (45) business days after the issuance of the Dispute Notice, or if the parties fail to meet within such forty-five (45) business days, either party may, by written notice to the other party, submit the dispute to binding arbitration, provided, however, that any demand for arbitration must be filed within six (6) months from the date of the issuance of the Dispute Notice. The above notwithstanding, nothing in this provision shall prevent either party from utilizing the JAMS's procedures for emergency relief to seek preliminary injunctive relief to halt or prevent a breach of this Provider Agreement.

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

14.09.08 Severability

In the event any provision of this **Arbitration** section of the Provider Manual shall be judged, declared, held, or ruled to be invalid, illegal, or unenforceable, in whole or in part, such provision shall be deemed severable, and it shall not invalidate or impair the **Arbitration** section of the Provider Manual as a whole.

14.10 Force Majeure

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

14.11 Anti-Kickback Statute, Stark Law and Caremark Compliance Program

Each party certifies that it shall not violate the federal anti-kickback statute, set forth at 42 U.S.C § 1320a-7b(b) ("Anti-Kickback Statute"), or the federal "Stark Law," set forth at 42 U.S.C § 1395nn ("Stark Law"), with respect to the performance of its obligations under this Provider Agreement. In addition, Caremark's Code of Conduct and policies and procedures on the Anti-Kickback Statute and Stark Law may be accessed at **caremark.com/pharminfo.**

14.12 Rebate Programs

Caremark has the right to submit all prescriptions relating to the Provider Agreement to pharmaceutical companies in connection with Caremark's rebate programs and any similar programs. Provider must not submit any of the prescriptions relating to the Provider Agreement to any pharmaceutical company for the purpose of receiving any rebate, discount or the like, except as authorized by Caremark in writing.

14.13 Eligible Person Communications

Provider understands and acknowledges that Caremark may communicate with Eligible Persons as required by Plan Sponsor, applicable Law, or as Caremark determines is necessary regarding matters that include, but are not limited to, Plan benefits, network design and composition, formulary and clinical issues, and manufacturer recalls.

15. Federal and State Laws and Regulations

15.01 Compliance with Laws

Notwithstanding anything in the Provider Agreement to the contrary, Provider must comply with all applicable Laws (including any implementing regulations) in performing its Pharmacy Services under the Provider Agreement including, but not limited to: applicable state and federal pharmacy Laws, the False Claims Act (31 U.S.C. 3729 et seq.), the Anti-kickback statute (42 U.S.C. 1320a-7b(b), Stark Law (42 U.S.C. 1395 nn), Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (45 C.F.R. Parts 160, 162, and 164) and the Controlled Substance Act (21 U.S.C. 801-971); and Caremark must comply with all applicable Laws (including any implementing regulations) in performing its duties under the Provider Agreement, provided, however, that in the event that Provider alleges that Caremark has not complied with an applicable Law, Provider shall not be entitled to a private right of action unless expressly permitted under the underlying applicable Law, and Provider shall not be entitled to any contract damages or other contract remedies against Caremark other than as specified by such underlying applicable Law. The foregoing notwithstanding, the parties agree this provision shall not be construed to bestow on either party a private right of action or other remedy not otherwise available under existing law.

Federal and state specific addenda, as updated from time to time to reflect regulatory changes, are set forth in the CVS Caremark Provider Manual State Addenda (available on the CVS Caremark Pharmacy Portal at **rxservices.cvscaremark.com**) and are incorporated herein by reference. Refer to section **1.05 CVS Caremark Pharmacy Portal** of the Provider Manual.

Provider shall develop and administer processes and protocols to ensure compliance with the Telephone Consumer Protection Act (TCPA), as may be amended, for all landline and mobile telephonic (including text message) outreach to Eligible Persons under this Provider Agreement, including outreach by subcontractors.

Appendix A - Appeals Process Documentation Guidelines

This is a sample of the appeals process letter and Documentation Guidelines that a Provider will receive with their preliminary discrepancy letter.

1. Introduction:

   The enclosed report lists discrepancies found as indicated on the Pharmacy Audit Acknowledgement signed by the pharmacy staff on duty at the time of the audit or submitted to you by Caremark. You have an opportunity to provide documentation to support your pharmacy's claims that are currently considered discrepant. Ensure all documentation provided for each discrepancy type is correct and relevant. Your immediate attention is important. All documentation must be **RECEIVED** by Caremark no later than the **due date** indicated on your cover letter.

2. Documentation Procedures:

   a. Pharmacy Audit Discrepancy List: The enclosed report lists discrepant claims by prescription number and date of fill. The D1 and D2 columns list the code for the discrepancy type.

   b. Documentation Guidelines: The enclosed guidelines describe the discrepancy types and the acceptable documentation required to support a potential resolution of the identified discrepancies.

   c. **ALL** acceptable documentation is required to include:

      i. Pharmacy NCPDP number

      ii. Prescription number as listed on the Discrepancy List

      iii. Date of fill listed on the Discrepancy List

      iv. Patient's full name and address

      v. For any document signed electronically, the signature audit log from the electronic signature vendor must be provided with the electronically signed document

3. Mailing Instructions:

   a. All documentation must be sent by the documentation **due date** indicated on the cover letter and in one package via **Certified, Express, Express with tracking, or regular USPS mail.** Address your correspondence to:

      CVS Caremark
      Attn: Audit Documentation
      Pharmacy Performance MC 020
      9501 East Shea Boulevard
      Scottsdale, AZ 85260-6719

   b. Caremark recommends sending documentation with tracking and maintaining a copy of all documentation sent.

   c. If the documentation is less than fifty (50) pages, the documentation can be faxed to **1-866-310-4135** instead of mailed; however, the images must be legible (e.g., documents on tamper resistant prescription pads may not be legible when faxed).

   d. If you need additional help, call Caremark Pharmacy Performance at **1-866-488-4709**.

4. Conclusion:

   a. ALL documentation received on or before the due date will be reviewed by Caremark and a Final Audit Discrepancy List will be mailed upon completion of review.

The documentation guidelines on the following pages apply to the extent permitted by applicable Law. Refer to the **CVS Caremark Provider Manual - State Addenda** for additional information on state specific requirements. State Addenda can be found on the CVS Caremark Pharmacy Portal at **rxservices.cvscaremark.com**.

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION*
CMP	COMPOUND	Original prescription hard copy, prescription dispensing label, and compound formulation record (recipe) cannot be found during the audit	1. Legible copy of the original compound formulation record (recipe) that was signed by the verifying pharmacist and that includes the names of all active and inactive ingredients, NDC numbers, and quantity used; (billing statements will not be accepted); **AND** 2. A copy of the prescription hard copy; **AND** 3. The prescription label with directions for use for each date of fill (if written "use as directed", follow Sig. documentation guidelines). **COMPUTER GENERATED, TELEPHONE RXs, OR TRANSFER RXs WILL NOT BE ACCEPTED.**
COU	COUPON	Coupon or another program not eligible to be applied to Caremark claim was used to reduce patient pay amount	This discrepancy does not require further documentation.
CPY	COPAY	Copays are required to be collected by pharmacy, where applicable by Law, and cannot be waived, reduced, increased, or discounted	A copy of a patient invoice showing the member copay amount along with evidence the copay was paid in full, such as a signed member statement listing the RX, date of fill (DOF), and copay paid amount; **AND (one of the following)**: If a credit card was used to pay the copay, provide credit card receipt showing copay amount, last four digits of the credit card number, authorization # and merchant report; **OR** If a check was used to pay the copay, provide a copy of the front and back of member's check; **OR** If cash was used to pay the copay, provide a member attestation indicating the amount paid in cash and bank deposits for copay amounts with documentation that correlates with the date of fill and date the copay was collected.
DAW	DISPENSE AS WRITTEN	DAW code submitted was different than the DAW instructions on the prescription	This discrepancy does not require further documentation.
DDB	DIFFERENT DRUG BILLED	Pharmacy billed a different medication and/or NDC than the one dispensed to the patient	This discrepancy does not require further documentation.

*Documentation guidelines apply to the extent permitted by applicable Law.

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION*
DIS	DRUG INVOICE SHORTAGE	Drug wholesaler invoices were not sufficient to support quantities billed	1. A summary report of drug purchases and returns directly from all wholesale distributors; **OR** 2. A copy of the original drug wholesale distributor invoices, if found; **OR** 3. Documentation of drug purchases via other sources consistent with DSCSA documentation requirements. **All documentation provided for Drug Invoice Shortage discrepancies must include at a minimum NDC, product name, quantity, invoice number, and dates of purchase.** Further verification of these documents may be required and communicated by Caremark, such as, but not limited to, proof of payment for stock transfers, payment history, copies of checks for drug stock buy-out, bill of sale, payment invoices.
DPC	DUPLICATE PAID CLAIM	Multiple claims for the same prescription fill were submitted but only one medication was dispensed to the member	This discrepancy does not require further documentation.
DWC	DATE WRITTEN CORRECTION	The written date submitted by the pharmacy does not match the date written on the prescription hard copy	This discrepancy does not require further documentation. The claim will be reprocessed for the correct date written.
ETL	EXCEEDS TIME LIMIT	Prescription was filled or refilled for a time period longer than that allowed by the Plan or applicable regulations	This discrepancy does not require further documentation.
INV	INVALID	The prescription and/or claim was invalid at the time the medication was dispensed to the Eligible Persons. Reasons for an Invalid discrepancy type include, but are not limited to, non-compliance with state and/or federal regulations, REMS, RMP, prohibited waiver of the Patient Pay Amount, circumvention of Plan design or adjudication edits, altered RX, etc.	This discrepancy does not require further documentation.
MIF	MISFILL	Prescription dispensed was filled with incorrect drug, strength, directions, or patient	This discrepancy does not require further documentation.

*Documentation guidelines apply to the extent permitted by applicable Law.

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION*
MP	MISSING PRESCRIPTION	Original hard copy prescription or computer-based prescription image cannot be found during the audit	1. Send a copy of the Prescriber's original written prescription, if found; **OR** 2. Send a signed statement from the Prescriber on Prescriber's business letterhead with clearly visible sourcing which includes medication, quantity, Sig, original fill date and authorized refill dates; **OR** 3. A Prescriber attestation on their prescription Rx pad, including medication, quantity, Sig., original fill date and authorized refill dates. **The Prescriber may fax their documentation to the pharmacy; however, Prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **AND YOU MUST INCLUDE:** 4. A copy of the dispensing label. If a prescription indicates "Use As Directed", follow Sig. documentation guidelines. **COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs WILL NOT BE ACCEPTED.**
NPI	INACCURATE PRESCRIBER ID	NPI/DEA number on the prescription did not match the NPI/DEA/ Prescriber identification number on the claim. The NPI/DEA number is required to be accurate on all controlled substances	This discrepancy does not require further documentation.
NSL	NO SIGNATURE LOG	The signature documenting receipt of the prescription drug cannot be found in the signature logs or the electronic database	1. Send a copy of the signature log with the signature highlighted, if found; **OR** 2. Send a signed statement from the patient verifying receipt of the medication; **OR** 3. Send a signed pharmacy patient profile from the patient including patient's address, phone number, Rx number and date(s) of fill. Each Rx must be initialed by the patient and dated. **AND**, in addition to the documentation in 1. or 2. or 3. above, if the medication is delivered in any manner other than directly at the Provider's location (e.g., to a home or business address of the patient) by carrier other than an employee of the provider, Provider must also provide: a. shipping method; b. shipment manifest; c. documentation of the prescription number(s) and Covered Item(s) delivered; and d. tracking documentation that the Covered Item was delivered.

*Documentation guidelines apply to the extent permitted by applicable Law.

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION*
OBC	OVER BILLED COMPOUND	One or more individual components within the compound claim is over billed	This discrepancy does not require further documentation.
OBQ	OVER BILLED QUANTITY	Quantity billed exceeded the amount authorized by the Prescriber, the quantity allowed under the Plan, or the quantity dispensed exceeds the days' supply submitted	This discrepancy does not require further documentation.
OTH	OTHER	A miscellaneous discrepancy type	Documentation must address the concern expressed on each claim in the Comments field on the initial discrepancy report.
PRD	PRESCRIBER DENIED	Prescription was denied by the Prescriber that was submitted on the claim	1. Send a copy of the Prescriber's original written prescription, if found; **OR** 2. Send a signed statement from the Prescriber on Prescriber's business letterhead with clearly visible sourcing which includes medication, quantity, Sig., original fill date and authorized refill dates; **OR** 3. Send a Prescriber attestation on their prescription Rx pad, including medication, quantity, Sig., original fill date and authorized refill dates. **The Prescriber may fax their documentation to the pharmacy, however, Prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **COMPUTER GENERATED, TELEPHONE RXS, OR TRANSFER RXs WILL NOT BE ACCEPTED.**
PTD	PATIENT DENIED	Patient denied requesting and/ or receiving the prescription	1. Send a copy of the signature log with the signature highlighted, if found; **OR** 2. Send a signed statement from the patient verifying receipt of the medication including patient's address, phone number, Rx number and date of fill.; **OR** 3. Send a signed pharmacy patient profile (signed by the patient) including patient's address, phone number, Rx number and date of fill. Each Rx must be initialed and dated by the patient.

*Documentation guidelines apply to the extent permitted by applicable Law.

DISCREPANCY CODE	DISCREPANCY TYPE	DISCREPANCY DEFINITION	ACCEPTABLE DOCUMENTATION*
RTS	REFILL TOO SOON	Prescription was refilled sooner than appropriate due to an incorrect days' supply on the previous fill date. If Provider dispenses the smallest commercially available package size and enters a day supply based on Plan limits, Provider maintains responsibility to adhere to appropriate refill intervals	This discrepancy does not require further documentation.
SIG	INSUFFICIENT DIRECTIONS FOR USE	Hard copy prescription does not include sufficient information to justify the quantity and days' supply billed	1. Obtain specific dosing instructions from the Prescriber. If dosing is PRN, specify patient's maximum weekly or monthly usage. Documentation outlining the patient's dose must be obtained from the Prescriber on Prescriber's business letterhead; **OR** 2. A Prescriber attestation on their prescription Rx pad, including medication, quantity, Sig., original fill date and authorized refill dates. **The Prescriber may fax their documentation to the pharmacy, however, Prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **NOTES OR VERBAL CONVERSATIONS WITH THE PRESCRIBER OR OFFICE STAFF WILL NOT BE ACCEPTED.**
UAR	UNDOCUMENTED AUTHORIZATION OF REFILL	The number of refills billed exceeds the number authorized by the Prescriber	Send a signed statement from the Prescriber on Prescriber's business letterhead or on a written Rx from the Prescriber, authorizing the dispensing. This must include medication, quantity, directions for use, original fill date and authorized refill dates. **The Prescriber may fax their documentation to the pharmacy, however, Prescriber documentation by attestation must clearly indicate sourcing (e.g., clearly visible fax signature that the document originated from the physician's office or physician's stamp on the letter).** **COMPUTER GENERATED, TELEPHONE PRESCRIPTIONS, TRANSFER RXs, WILL NOT BE ACCEPTED.**
VAF	VACCINE ADMININSTRATION FEE	No documentation that a vaccine was administered	1. Send a copy of a vaccine administration log with the signature highlighted, if found; OR 2. Send a signed statement from the patient verifying the vaccine was administered.
WP	WRONG PATIENT	Patient identified on a hard copy prescription is not the same patient on the claim	Send a signed statement from the cardholder indicating that the patient whose name is on the prescription is covered by the indicated Plan.

*Documentation guidelines apply to the extent permitted by applicable Law.

Glossary of Terms

Administration Fee means the administration fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, the claim adjudication system, which may be reduced to the Incentive Amount Submitted (NCPDP field #438-E3) by the Provider.

AWP or Average Wholesale Price means a Price Type including AWP, AAWP and GEAP, published by Medi-Span (with supplements), a Price Type published by MICROMEDEX, or other similar nationally recognized reference which Caremark may select from time to time.

AWP Discount means the AWP percentage discount that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claim adjudication system, each as may be amended from time to time.

Caremark Documents means the Provider Agreement, schedules thereto, addenda, the Provider Manual and all attachments thereto including Appendices and this Glossary of Terms, Federal Laws and Regulations, State Laws and Regulations, information transmitted by Caremark to Provider through the claim adjudication system, information transmitted by Caremark to Provider specifically designated by Caremark as a "Caremark Document" which may include educational materials related to products, programs, services, and Plan Sponsor announcements, and such other communications by Caremark to Providers through the CVS Caremark Pharmacy Portal.

Chargeback means collection by Caremark of amounts paid to a Provider, in whole or in part, that were determined to be owed, including but not limited to, amounts for discrepant claim(s), claim(s) submitted in breach of the Agreement, or identified overpayment(s).

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

Covered Item means any drug, medication, device, product, or service covered, in whole or in part, in accordance with and subject to the terms of a Plan covering an Eligible Person.

Dispensing Fee means the dispensing fee that, with respect to a network, is set forth in the Provider Agreement, an addendum hereto, a network enrollment form, or the claim adjudication system, each as may be amended from time to time.

Dispensing Pharmacy means the pharmacy that is giving or delivering the Covered Item to the Eligible Person.

Dispensing Practitioner means a duly licensed and established practitioner (e.g., MD, DO, RN, NPA, and RPh) operating under a medical license or other appropriate license and that dispenses and sells Covered Items to Eligible Persons through in-person hand delivery at the point of care, solely to the dispensing practitioner's patients in the regular course of the practitioner's practice.

Eligible Person means a person or animal entitled to a Covered Item pursuant to a Plan.

Law means any Federal, State, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, sub-regulatory guidance (including but not limited to, model contracts between the state Medicaid agency and managed care organizations, and other guidance from State Medicaid Agencies, such as Medicaid Manuals, Bulletins, and other issuances), order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) order, specified standards, or objective criteria contained in or which are (by express reference or necessary implication) a condition of granting any applicable permit, license or approval required by Caremark, Provider, or a Plan Sponsor, or other legislative or administrative action of the United States of America, or state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

Licensed Pharmacist means a pharmacist licensed in the United States (including U.S. territories).

MAC or Maximum Allowable Cost means a unit price that has been established as the reimbursement amount to Provider for certain multiple-source drugs without regard to the specific manufacturer whose drug is dispensed.

Medical Foods: The term medical food, as defined in section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation."

Patient Pay Amount means the amount an Eligible Person must pay to Provider at the time a Covered Item is dispensed as indicated by the claim adjudication system, which may include but is not limited to copayments, coinsurance, deductibles, transaction fees, access fees, and/or taxes.

Pharmacy Services/Provider Services means all services including the provision of prescription drugs usually and customarily rendered by a Provider and Licensed Pharmacist or Dispensing Practitioner licensed to provide pharmacy services in the normal course of business, including services mandated by applicable Law. Pharmacy Services may include, but not be limited to: the maintenance of Eligible Person profiles; the interpretation of prescriptions; the selection of medications and medical devices; the sale of compounding or dispensing of medications and medical devices (also includes over-the-counter medications [OTCs] and supplies covered by or used in conjunction with a pharmacy benefit); the counseling of Eligible Persons, which may consist of information about the proper storage, dosing, side effects, potential interactions and use of the medication dispensed; the monitoring of appropriate drug use; and the implementation of drug utilization review programs and other clinical programs and services.

Plan means that portion of a Plan Sponsor's pharmacy benefit plan that relates to Covered Items with respect to a group of Eligible Persons.

Plan Sponsor means the entity that contracts with Caremark or any of Caremark Rx, L.L.C.'s affiliates for pharmacy benefit management services, which entity could be, among other things, an insurance company, self-insured group, health maintenance organization, preferred provider organization, multi-employer trust or third-party administrator.

Prescriber means a physician, dentist, physician's assistant, optometrist or other health care professional authorized by law to write prescriptions for prescription drugs within the scope of practice as designated by regulatory agency.

Price Type means a price of a given product for the fill date submitted at the time of claim adjudication as published by a Pricing Source and loaded into the claim adjudication system. Price Type may include, but is not limited to, AWP (Average Wholesale Price), WAC (Wholesale Acquisition Cost), NADAC (National Average Drug Acquisition Cost), ASP (Average Sales Price), FUL (Federal Upper Limit), state-specific AAC (Actual Acquisition Cost), Average AWP (AAWP), Generic Equivalent Average Price (GEAP), etc.

Pricing Source means either a nationally recognized reference that Caremark may reasonably select from time to time or for Plan-specific pricing, a Plan Sponsor, state or other third-party publisher of pricing data supplied to Caremark.

Product Identifier means a series of numerical or alphanumerical digits managed by various organizations and published by Medi-Span, First Databank, MICROMEDEX or other nationally recognized reference which Caremark may reasonably select from time to time, that are used to identify a specific product that, where applicable, is used and formatted according to the NCPDP Product Identifiers Standard. The Food and Drug Administration (FDA) National Drug Code (NDC) as published by Medi-Span and formatted to the 11-digit format defined by NCPDP is an example of a Product Identifier.

Provider means a provider of Pharmacy Services that is the signatory to the Agreement and who must provide all services including the provision of prescription drugs usually and customarily rendered by a provider, Licensed Pharmacist or Dispensing Practitioner licensed to provide such Pharmacy Services in the normal course of business, including services mandated by applicable Law.

Retail Pharmacy means a duly licensed and established community pharmacy or dispensing practitioner that serves walk-in patients and that dispenses and sells non-specialty prescription drugs to Eligible Persons through in-person hand delivery at the point of sale. Participation in Caremark's retail networks is limited to pharmacies (or dispensing practitioners) that are a "Retail Pharmacy". Refer to section **3.04 Standards of Operation** of the Provider Manual.

Third-Party Agreement means an agreement between Caremark and a Caremark client in which Caremark serves as an auditor for that client's participating network pharmacies.

Usual and Customary Price or U&C means the lowest price Provider would charge to a particular customer if such customer were paying cash for an identical prescription on that particular day at that particular location. This price must include any applicable dispensing fee and/or level of effort. This price must include any applicable discounts offered to attract customers.