PDMI

Pharmacy Manual

Introduction

Pharmacy Data Management, Inc. (PDMI), founded in Poland, Ohio, in 1984, provides technology and specialized industry solutions for managing health through prescription drug programs for national and regional health plans, Pharmacy Benefit Managers (PBMs), hospice organizations, 340B and drug manufacturer assistance programs, as well as various healthcare-related industries.

We have a long-standing reputation for offering responsive, compassionate, and consistent customer service since 1984. Beyond that, our IT solutions, expertise in the pharmacy industry and our 340B program administration is what sets us apart from others in the industry.

PDMI offers a suite of flexible, scalable solutions to help our client meet their business objectives, including those for:

- Patient Assistance Programs
- Discount Card Programs
- Commercial Health Plans
- Hospice and Long-Term Care Services
- Patient Support Programs & Administrators

Our proprietary systems offer our clients the ability to tailor each solution to their needs.

Provider Manual

The Network Pharmacy Manual ("Manual") includes the policies and procedures for participation in Provider Networks that PDMI manages. As referenced and incorporated into the PDMI Participating Pharmacy Services Agreement ("Agreement"), all pharmacies must monitor for changes and comply with directives within the Manual. This Manual will be updated as necessary and is subject to change without notice. The current version of this manual is posted on the PDMI website at https://www.pdmi.com/pdmi/resources/network-pharmacy-support.

Participating Pharmacy reimbursement rates, reporting fees, and other costs or expenses are not reflected in, or amended by revisions to this Provider Manual. In the event of a conflict between the terms of the Agreement and those set forth in this Provider Manual, the terms of the Agreement will control.

PDMI Contact Information

Pharmacy Data Management, Inc. can be contacted at:

Mailing Address
Pharmacy Data Management, Inc.
8530 Crossroads Drive
Poland, Ohio 44514

Main Phone: (800) 800-7364
Sales: (855) 326-2160
IT Services: (800) 800-7364 x5409

Pharmacy Call Center: (800) 767-4226 (option 1)
Note: have ready your Pharmacy NABP or NCPDP number.

The regular Call Center hours are:

Monday through Friday from 8:30 AM to 10:00 PM ET
Saturday from 9:00 AM to 5:00 PM ET
Sunday from 12:00PM to 4:00PM ET

Audits
audit@pdmi.com

Accounts Payable
pharmacypayables@pdmi.com

MAC
mac@pdmi.com

Pharmacy Network Participation Requirements

Network Participation
Pharmacy may request a Participating Pharmacy Services Agreement to join the pharmacy network by contacting PDMI via:

- Email
- Phone
- Fax

Applicants must provide the pharmacy name, corresponding NCPDP number, contact name, business address, telephone number, fax number, and email address.

Credentialing
A Pharmacy must complete and submit a credentialing application to participate in the PDMI pharmacy network. All information on the application must be complete and accurate.

Required documentation include:

1. Pharmacy State License– Must be current
2. Pharmacist in Charge State License– Must be current
3. DEA Certificate– Must be current
4. Professional Liability Insurance– Must meet the $1 Million per claim or occurrence, $3 Million Aggregate threshold
5. Cyber security and data breach protection
6. Federal Tax Id Certificate
7. W-9
8. Photograph of storefront – Address must be visible in photograph

Cyber Insurance
Pharmacy shall maintain network risk and cyber liability coverage (including coverage for unauthorized access, failure of security, breach of privacy perils, as well at notification costs and regulatory defense) in an amount of not less than $2,000,000. Such insurance shall be maintained in force at all times during the term of the Agreement and for a period of two years thereafter for services completed during the term of the Agreement.

PSAO Credentialing
PDMI will requires PSAO to credential each pharmacy within the PSAO to assure that each pharmacy meets PDMI's credentialing requirements.

Chain Credentialing
Chains must submit a signed attestation that confirms all pharmacies under the applicable chain code hold current and active state licensure, have liability coverage meeting PDMI requirements and attests they will continue to hold such current and active licensure and liability coverage during the term of the Agreement. In addition, the chain must provide:

- Store Roster
- Licensure Number and Expiration Date (each store)
- Pharmacist-in-charge License Number and Expiration Date (each store)
- DEA License Number (each store)
- Professional Liability Insurance - Must meet the $1 Million per claim/occurrence, $3 Million Aggregate threshold
- Cyber coverage
- W-9

Chain agrees to provide an updated store listing with respective licensure status and a copy of updated general liability insurance upon request, or in the event of change.

Exclusion and Preclusion Lists
Pharmacy may not appear on any state or federal exclusion lists to participate within PDMI Pharmacy Networks.

Additional Suspensions and Termination Provisions
PDMI may suspend a Pharmacy from participation in its Network if the Pharmacy has been identified or under review for engaging in any behavior or practice that poses a risk to the health, welfare, or safety of a Patient.

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

The following practices may result in claims chargeback, suspension, and termination from the Network:

- Participating Pharmacies sharing ownership, partial ownership, officers, affiliates, principals, or other relationships with Pharmacies that had been previously suspended or terminated from PDMI's Network
- Shipping medications or supplies to patients without their consent or initiation
- Shipping to states where Pharmacy is not currently licensed and insured
- Obtaining prescriptions using telemarketing companies or services
- Submitting a large number of test claims
- Not collecting applicable Patient copayments at the time of Pharmacy service
- Failure to cooperate or provide access to books, records, or the facility during a PDMI initiated onsite audit
- Discovery of no onsite pharmacist present during Pharmacy's hours of operation
- Attempting to adjudicate or adjudicating components of a compound drug as separate ingredients, single-NDC claims
- Attempting to adjudicate or adjudicating claims for compound drugs in which the ingredients are not supported by a medically acceptable
  indication through the same administration route for the condition being treated
- Attempting to adjudicate or adjudicating claims for compound drugs in which the same or similar formulation is available on the market
- Discovering inventory shortages upon invoice reconciliation when comparing Pharmacy drug utilization and purchase invoice records
- Failure to respond to recredentialing request or audit; or
- Refusing to service a Patient due to reimbursement rates.

Dispute Resolution/Appeal Process

The Parties shall make a good faith effort to resolve any disputes arising during the term of the Agreement. If they are unable to resolve the dispute through informal discussions, either Party may submit a written complaint to the other party describing and proposing a manner of resolving that dispute. The Party receiving that complaint shall respond by accepting, rejecting, or modifying that proposal, in writing, within thirty (30) days of the date that it receives the complaint. If the dispute cannot be resolved as indicated herein, the parties reserve the right to pursue legal options.

Updating Pharmacy Information

Pharmacy must update its demographic and affiliation information in its NCPDP DataQ profile in real time. PDMI will rely upon data listed within NCPDP DataQ profile as using NCPDP DataQ is industry standard.

Privacy and Security Standards

Pharmacy will adhere to industry best practices regarding security, including but not limited to, the requirements under applicable state and federal laws and regulations, including, but not limited to, the federal HITECH Act, the Health Insurance Portability and Accountability Act of 1996 and their implementing regulations, 45 C.F.R. parts 160 and 164 (collectively, "HIPAA Regulations").

Specific Network Pharmacy Requirements

Mail Order Requirements

Patients may have Products filled through PDMI's designated mail order Pharmacy provider.

i. **Shipping.** Once a prescription for a Covered Product has been transmitted to a mail order Pharmacy in accordance with applicable Laws, such Pharmacy will promptly prepare, package, and ship the applicable Covered Product to the Patient or other authorized person or entity in accordance with the prescription order. The Pharmacy shall ship (at no additional charge) Covered Product to Patients via U.S. Postal Service (USPS) or other appropriate carrier to the address provided by Client and/or the Patient, provided such addresses are located in the United States or its territories. Patient's physical delivery address cannot be a Post Office box. All Covered Product shall be shipped in a manner to assure the integrity of the Covered Product per manufacturer specifications and the standards of professional conduct and practice prevailing in the industry, including temperature controls. The mail order Pharmacy is responsible for all confirmed lost or missing Covered Product not received by Patients and for Covered Product damaged during shipment. Pharmacy shall immediately reship (via overnight delivery) any such lost, missing, or damaged Covered Product upon notification of such occurrence and shall not bill PDMI, Client or Patient any amount for such reshipped Covered Product (including any Copayment amount or shipping charges).

ii. **Patient Counseling.** The dispensing mail order Pharmacy shall provide Patients with instructions and patient counseling on the use of the Covered Product and such other disclosures required by applicable Law. The dispensing mail order Pharmacy shall also provide Patients with access to a pharmacist and customer service representative via a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

iii. **Transfers.** PDMI may assist in the transfer of prescriptions to its designated mail pharmacy.

Specialty Requirements

Pharmacy must supply drug roster on quarterly basis to PDMI. Drug roster must include the 11-digit NDC, Label Name, and 14-digit GPI. Pharmacy must make note of any limited or exclusive distribution medications. Drug manufacturer face sheet is to be supplied upon request.

Patients may have Covered Product specialty medication prescriptions filled through PDMI's designated specialty Pharmacy provider.

i. **Shipping.** Once a prescription for a specialty medication has been transmitted to a specialty Pharmacy in accordance with applicable Laws, such Pharmacy will promptly prepare, package and ship the applicable Covered Product to the Patient or other authorized person or entity in accordance with the prescription order. The specialty Pharmacy shall ship (at no additional charge) Covered Products to Patients via U.S. Postal Service (USPS) or other appropriate carrier to the address provided by Client and/or the Patient, provided such addresses are located in the United States or its territories. Patient's physical delivery address cannot be a Post Office box. All Covered Products shall be shipped in a manner to assure the integrity of the Covered Products per manufacturer specifications and the standards of professional conduct and practice prevailing in the industry, including temperature controls. The specialty Pharmacy is responsible for all confirmed lost or missing Covered Products not received by Patients and for Covered Products

damaged during shipment. Pharmacy shall immediately reship (via overnight delivery) any such lost, missing, or damaged Covered Product upon notification of such occurrence and shall not bill Client or Patient any amount for such reshipped Covered Product (including any Copayment amount or shipping charges).

ii. **Patient Counseling.** The dispensing specialty Pharmacy shall provide Patients with instructions and patient counseling on the use of the Covered Product and such other disclosures required by applicable Law. The dispensing specialty Pharmacy shall also provide Patients with access to a pharmacist and customer service representative via a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

iii. **Transfers.** PDMI may assist in the transfer of prescriptions to its designated specialty pharmacy.

Long Term Care Requirements

Pharmacy must be a state-licensed pharmacy providing enhanced pharmacy and clinical services to individuals who have certain comorbid and medically complex chronic conditions and who reside in skilled nursing facilities, nursing facilities, or any other applicable setting as determined by the Centers for Medicare and Medicaid (CMS). Enhanced pharmacy and clinical services include, but are not limited to, medication dispensed in special packaging, drug utilization review (DUR), and availability of medication delivery and on-call pharmacists 24-hours per day, seven days per week.

Pharmacy is required to provide ongoing in-service training to assure that LTC facility staff are proficient in Pharmacy's processes for ordering and receiving of medications. Pharmacy shall be responsible for return and/or disposal of unused medications following discontinuance, transfer, discharge, or death as permitted by Pharmacy's State Board of Pharmacy. Controlled substances and out of date substances shall be disposed of within state and Federal guidelines.

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

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

<u>Pharmacy Operations and Prescription Orders</u>

Pharmacy shall provide services of a dispensing pharmacist to meet the requirements of pharmacy practice for dispensing prescription drugs to long term care ("LTC") residents, including but not limited to the performance of drug utilization review ("DUR"). In addition, a Pharmacy pharmacist shall conduct DUR to routinely screen for allergies and drug interactions, to identify potential adverse drug reactions, to identify inappropriate drug usage in the LTC population, and to promote cost effective therapy in the LTC setting. Pharmacy shall also be equipped with pharmacy software and systems sufficient to meet the needs of prescription drug ordering and distribution to an LTC facility. Further, Pharmacy shall provide written copies of Pharmacy's procedures manual and said manual must be available at each LTC

facility nurses' unit. Pharmacy is also required to provide ongoing in-service training to assure that LTC facility staff are proficient in Pharmacy's processes for ordering and receiving of medications. Pharmacy shall be responsible for return and/or disposal of unused medications following discontinuance, transfer, discharge, or death as permitted by Pharmacy's State Board of Pharmacy. Controlled substances and out of date substances shall be disposed of within state and Federal guidelines.

Emergency Log Books

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

Payment of Claims

Pharmacy shall have not less than thirty (30) days, nor more than ninety (90) days to submit a claim for payment. (42 C.F.R. §§ 423.505(b) (20), 423.505(i)(3)(vii)).

Home Infusion Requirements

Drug Form

Pharmacy must be capable of delivering home-infused drugs in a form that can be administered in a clinically appropriate fashion.

Following Discharge

Pharmacy shall ensure that all home infusion drugs be delivered within 24 hours of discharge of a Beneficiary from an acute care setting, or later if so prescribed.

IV Medications

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

Miscellaneous Reports, Forms and Prescription Ordering Supplies

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

Indian Health Care Requirements

Definitions

1. "Indian Health Service" shall mean the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act ("IHCIA"), 25 USC §1661.
2. "Indian Tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603.
3. "Tribal Organization" has the meaning given than term in Sec. 4 of the IHCIA, 25 USC §1603.
4. "Urban Indian Organization" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603.
5. "Indian" has the meaning given to that term in Sec. 4 of the IHCIA, 25 USC §1603.

Insurance and Indemnification

As an IHS provider, FTCA coverage obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. § 2671-2680. Nothing in the Agreement or Addendum shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the Plan will be held harmless from liability.

A Provider which is an Indian tribe or a tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the Federal Tort Claims Act (FTCA) pursuant to Federal law (Pub.L. 101-512, Title III, §314, as amended by Pub.L. 103- 138, Title III, §308 (codified at 25 USC §450 F note); and regulations at 25 CFR Part 900, Subpt. M. To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to section 224(g)- (n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Pub.L. 104-73, (codified at 42 USC §233(g)-(n)) and regulations at 42 CFR Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Further, nothing in the Agreement, Addendum or any addendum thereto shall be interpreted to authorize or obligate Provider or any employee of such Provider to operate outside of the scope of employment of such employee, and Provider shall not be required to indemnify the Company or a Part D Client.

Licensure

States may not regulate the activities of IHS-operated pharmacies nor require that the IHS pharmacists be licensed in the State where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a pharmacy or dispensary of a tribe, tribal organization, or urban Indian organization. The Parties agree that during the term of the Agreement and Addendum, IHS pharmacists shall hold state licenses in accordance with applicable federal law, and that the IHS facilities where the pharmacies and dispensaries are located shall be accredited in accordance with federal statutes and regulations. During the term of the Agreement and Addendum, the parties agree to use the IHS facility's Drug Enforcement Agency (DEA) number consistent with federal law.

To the extent that any directly hired employee of a tribal or urban Indian Provider is exempt from State regulation, such employee shall be deemed qualified to perform services under the Agreement, Addendum and all addenda thereto, provided such employee is licensed to practice pharmacy in any

State. This provision shall not be interpreted to alter the requirement that a pharmacy hold a license from the Drug Enforcement Agency.

To the extent that the Provider is exempt from State licensing requirements, the Provider shall not be required to hold a State license to receive any payments under the Agreement, Addendum, and any addendum thereto.

Applicability of other Federal laws

Federal laws and regulations affecting a Provider, include but are not limited to the following:

1. An IHS provider:
    a. The Anti-Deficiency Act 31 U.S.C. § 1341;
    b. The Indian Self Determination and Education Assistance Act ("ISDEAA"); 25 USC § 450 et seq.;
    c. The Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 2671-2680;
    d. The Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
    e. The Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 CFR Part 5b;
    f. Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2;
    g. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164;
    h. The IHCIA, 25 U.S.C. § 1601 et seq.

2. A Provider who is an Indian tribe or a tribal organization:
    a. The ISDEAA, 25 USC §450 et seq.;
    b. The IHCIA, 25 USC §1601, et seq.;
    c. The Privacy Act, 5 USC §552a and regulations at 45 CFR Part 5b;
    d. 5.2.e The HIPAA and regulations at 45 CFR parts 160 and 164.
    e. The FTCA, 28 USC §§2671-2680;

3. A Provider who is an urban Indian organization:
    a. The IHCIA, 25 USC §1601, et seq.;
    b. The Privacy Act, 5 USC §552a and regulations at 45 CFR Part 5b;
    c. The HIPAA and regulations at 45 CFR parts 160 and 164.

Persons eligible for services of Provider

The Parties agree that the IHS Provider is limited to serving eligible IHS beneficiaries pursuant to 42 CFR Part 136 and section 813(a) of the IHCIA, 25 USC §1680c: who are also eligible for Medicare Part D services pursuant to Title XVIII, Part D of the Social Security Act and 42 CFR Part 423. The IHS Provider may provide services to non-IHS eligible persons only under certain circumstances set forth in IHCIA section 813(b) and in emergencies under section 813(c) of the IHCIA.
The Parties agree that the persons eligible for services of the Provider who is an Indian tribe or a tribal organization or a Provider who is an urban Indian organization shall be governed by the following authorities:

a) Title XVIII, Part D of the Social Security Act and 42 CFR Part 423;

b) IHCIA sections 813(a) and 813(c), 25 USC §1680c (a) and (c);
c) 42 CFR Part 136;
d) And the terms of the contract, compact or grant issued to the Provider by the IHS for operation of a health program.

Rural Pharmacy Requirements
Pharmacy may request special rural rates reimbursements due to lack of proximity to other pharmacies within a 15-mile radius. PDMI will make a determination as to Pharmacy eligibility for rural rates reimbursement. Physical location and zip code classification may be used for this determination. PDMI has sole discretion to remove rural designation at any time if the Pharmacy no longer meets the rural pharmacy requirements.

Claims Processing

Pharmacy shall be responsible for paying all fees or costs associated with its electronic submission of claims, such as point-of-sale, switch charges, and data reporting charges and electronic fees ("the System"), unless otherwise prohibited by law.

Claim Submission Requirements
Pharmacy shall transmit all claims electronically using the most current National Council for Prescription Drug Plans ("NCPDP") Telecommunications Standard Format. Unless modified by state law, Pharmacy shall submit a Claim for payment within thirty (30) days of dispensing a Product to Patients. Pharmacy agrees to submit all Claims for Products and shall dispense Products in accordance with the terms and conditions of the applicable Agreement. Any Claim not picked up or received by Patient after fourteen (14) days from the date of submission shall be reversed within the System.

Claim Denials
If any Claim is denied by the System, Pharmacy will evaluate the cause of denial and exercise professional judgment to provide Pharmacy Services. If the cause of denial cannot be resolved, Pharmacy will notify and extend an offer to dispense the Covered Product at Pharmacy's U&C price. System may reject NDCs that are identified as repackaged medications, as non-covered drugs.

Reversals and Reprocessing of Claims
To ensure accuracy of claims adjudicated, pharmacy must use reversals to send accurate claims. Billing window may vary by; however, PDMI shall not process any claim, nor incur any liability for any claim, submitted after 365 days from date of dispense by Pharmacy.

Copayments
Pharmacy agrees to collect from each the applicable Copayment amount on each claim as determined by the processing of the claim by the System. Pharmacy shall not waive, rebate, accept or offer a coupon for discount or in any other way reduce or discount any Patient's Copayment, except to reduce for coordination of benefits or as otherwise initiated by Companyor the System.

DUR Codes
Pharmacy shall monitor and respond to drug utilization review communicated by the system. Pharmacists shall exercise professional judgment in dispensing a Covered Product and addressing and resolving drug utilization review communications.

DAW Codes
Pharmacy must use appropriate DAW codes in accordance with NCPDP standards.

Universal Claim Form
In the event the online System is temporarily inaccessible, Pharmacy shall make reasonable attempts at retransmission. Should these attempts fail, Pharmacy may submit claims on Universal Claims Forms or other NCPDP-standard electronic format that is consistent with prevailing state and federal regulations. Pharmacy shall submit all hard copy claims within one (1) year after date of dispense.

PDMI will process all Universal Claim Forms in a timely manner. In the event PDMI receives a Universal Claim Form, PDMI will ensure form is sent to appropriate entity.

Coordination of Benefits

Coordination of Benefits establishes the order in which pay Claims when more than one plan exists. When more than one Client is involved, the following will apply to Claim submission:

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

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

Pharmacy shall use its commercially reasonable efforts to perform coordination of benefit services at the point of sale and at the time of service; and to cooperate and share with Company any information that it has regarding claims for Pharmacy Services for which another third-party payer may be responsible due to coordination of benefits or subrogation.

Compound Drugs
Compound drugs dispensing fee will be reimbursed in accordance with level of effort. Level of effort shall be defined as the correct code indicating the level of effort as determined by the complexity of decision making or resources utilized by a pharmacist to perform a professional service.

Pricing and Compensation

Payer Sheet

Payer Sheets are published on www.pdmi.com. Please refer to the PDMI website for all current payer sheets. Any updates to the payer sheet will be reflected on the PDMI website. For further assistance, please contact PDMI directly.

Pay Cycle

Payment will be sent to pharmacies on bi-weekly basis contingent upon PDMI receiving funds from its Client.

Check Reissuance

All check reissuance requests should be directed to finance@pdmi.com. Please confirm the address to which the check should be sent and provide the following information: Pharmacy NABP, Check Number, Check Total, and Reason for Reissue. Most checks are reissued in under 3 weeks after all the above information is received and reissuance verified.

Remittance Advice

PDMI sends physical remittances to the mailing address or physical address the Pharmacy Provider provided on the Credentialing Application, or as notified via request, or as notified via NCPDP DataQ information. These remittances are sent to the pharmacy at the time of check issuance.
Pharmacies that wish to receive Electronic Remittance Advice can request this set up by visiting https://pdmi.com/resources/network-pharmacy-support or contacting pharmacypayables@pdmi.com.

Electronic Funds Transfer

By default, PDMI sends physical check payments to the mailing address or physical address the Pharmacy Provider provided on the Credentialing Application, or as notified via request, or as notified via NCPDP DataQ information.

To be eligible to receive funds electronically, pharmacy must first also agree to accept 835 remittances electronically. Chain or PSAO providers that request EFT will be required to have all their affiliates to fall under that EFT standard.

Pharmacy Providers may submit an Electronic Funds Transfer form located at https://pdmi.com/resources/network-pharmacy-support under “Request for Electronic Funds Transfer.” All questions may be submitted to pharmacypayables@pdmi.com.

Modification of Pricing Methodology

If the industry standard referenced for pricing hereunder changes the methodology for determining drug price in a way that materially changes the pricing or economics of this Agreement, the Parties agree to negotiate in good faith to modify the pricing terms to preserve the relative economics of the Agreement. Otherwise, the referenced values used to set the pricing terms hereunder shall be fixed as of the day prior to the methodology change for the duration of the Agreement.

Maximum Allowable Cost (MAC)

MAC Pricing

PDMI maintains a Maximum Allowable Cost (MAC) pricing program to be used for pharmacy provider reimbursement on generic products. The MAC program aligns the incentives for the Client (health plan or payer), the Patient, and the Pharmacy. The MAC pricing will ensure cost effective generic drug purchasing habits while maintaining reasonable pharmacy profit incentives to dispense market appropriate generic equivalent products.

The PDMI managed network MAC application undergoes a review on a weekly basis to account for potential market fluctuations that can impact wholesale acquisition costs. If the review results in an indication for a change in a MAC price for a given GPI, the MAC price will be updated accordingly in real time with an appropriate effective date.

Reimbursement for a drug subject to maximum allowable costs is based solely on a specific drug; therapeutically equivalent drugs are listed in the most recent version of the Orange Book (USDA Approved Drug Products with Therapeutic Equivalence Evaluations).

Pharmacies receive daily notifications through their switch relays when they transmit claims and/or by calling the PDMI help desk. Pricing requirements are subject to all state laws and regulations.

Pharmacy providers may appeal a reimbursement for a MAC generic claim and request a review of the MAC pricing. All appeals and questions regarding MAC should be directed to mac@pdmi.com.

MAC Appeals

Please submit the MAC appeal via the procedure described below. All submissions are required in the electronic format provided. Invoices detailing the acquisition costs may be taken into consideration for the appeal but are not required. The requesting party will receive an email response detailing whether the appeal has been approved for a price update or denied. PDMI will comply will all state policies regarding MAC pricing and appeals.

To submit a MAC Appeal, fill out the provided MAC Appeal Form located at https://pdmi.com/resources/network-pharmacy-support in its electronic format. Required fields are highlighted in yellow on the MAC Appeal Form. Submit the completed file to mac@pdmi.com.

Pharmacies contracted directly with PDMI may appeal directly to PDMI using the process provided. If the pharmacy provider is member of a chain, franchise, Pharmacy Services Administrative Organization (PSAO), or similar organization, please direct your appeals to your corporate office or third-party administrator office. Corporate HQs and PSAO groups can then appeal on behalf of all their member pharmacy providers.

Audits

In accordance with the Participating Pharmacy Agreement, PDMI has the right to perform audits of our network pharmacies. All claims are subject to audit. A Pharmacy Audit is a formal review of documents and processes to ensure pharmacy's compliance with network agreements and pharmacy processes. An important purpose in performing an audit is to support overall Fraud, Waste and Abuse (FWA) monitoring of pharmacy claims with the goal of maintaining the integrity of our national Pharmacy Network. Please refer to the below section "Fraud, Waste and Abuse (FWA)" for more information.

Process and Procedures

Desktop Audit: The Desktop Audit begins with a Letter of Intent to Audit submitted to the Pharmacy, which includes a request for the full hard copy prescription(s) and signature logs, if applicable, for the prescriptions to be audited. Digital images provided by Pharmacy shall suffice as a copy of the prescription. The Pharmacy will have thirty (30) calendar days, or as required by state law, to submit all documentation requested by the audit entity.

If the Pharmacy is unable to submit the audit requested documentation within the 30-day window, or as required by law, Pharmacy must contact PDMI or its auditing entity prior to the end of the 30-day window to discuss the reason for the delay and to determine a date when the documentation will submitted by Pharmacy; however, no delay beyond thirty (30) additional calendar days shall be granted to Pharmacy to submit such documentation. Failure by Pharmacy to make such contact within the 30-day timeframe, or Pharmacy's failure to produce the requested documentation shall be a breach of the Agreement.

Onsite Audit: The Onsite Audit may begin with a Letter of Intent to Audit submitted to the Pharmacy. In general, the Pharmacy is notified via mail carrier for scheduling purposes; however, written notification is not mandatory for this type of audit to occur.

The Letter of Intent to Audit may request a specific date and time for the Onsite Audit to occur and while all audits may be performed on a mutually agreed-upon day and time, a scheduled onsite audit is targeted to begin within ten (10) business days of Pharmacy having received a written request by PDMI to perform such onsite audit. Pharmacy shall allow the auditing entity full access to requested audited documents.

Note that Pharmacy practices classified as unprofessional or unsafe during the onsite audit may result in actions taken against the Pharmacy up to and including termination of the Pharmacy Agreement, issuance of corrective actions and/or PDMI or the auditing entity reporting to applicable regulatory agencies.

For both Desktop and Onsite Audits, within thirty (30) days following PDMI's or the auditing entity's receipt of Pharmacy's audit documentation, Pharmacy shall receive PDMI's Initial Findings. The Initial Findings Letter shall clearly state whether the claims' audits has resulted in a required recoupment from the Pharmacy. See below Audit Recovery for more information.

Investigative Audit: Investigative audits are more extensive and detailed in scope in comparison with desk or onsite audits. Additional documentation may be requested from the Pharmacy beyond the

standard request for copies of prescriptions and delivery logs. The time frame for reviewing documentation may be extended depending on the nature of the investigation.

If the Pharmacy chooses to appeal the findings stated in the Initial Findings Letter, it may do so within thirty (30) calendar days, or as required by state law. Pharmacy must submit written additional documentation that support its findings and return such findings to PDMI or its auditing entity within 30 calendar days. Upon review of these documents, PDMI or its auditing entity shall determine if its original decision found in the Initial Findings Letter will be overturned or upheld, and a Final Findings Letter will be sent to the Pharmacy by the auditing entity.

If no appeal of the Initial Findings Letter is submitted by Pharmacy, or if no response is received by PDMI or its auditing entity from the Pharmacy within such 30 calendar days, PDMI shall determine such non-response as acceptance of the audit findings.

Note that timeframe allowances described above may be shortened for investigative reviews, Client or audits initiated as a result of Patient complaint.

Audit Recovery
For claims audits that result in a recovery of funds from Pharmacy, PDMI shall off-set any amounts due against funds due to Pharmacy, as permitted by state law, such funds will be subtracted from any future payments to the pharmacy.

Fraud, Waste and Abuse (FWA)
Suspected FWA audits are not subject to the audit restrictions set forth above. FWA audits, other than those expressly required by applicable law, shall be conducted for the sole and specific purpose of addressing PDMI's reasonable, good-faith concerns regarding suspected fraud, waste, and abuse. For clarification, PDMI and shall not be prohibited from auditing compound prescriptions.

Fax cover sheet

Date: DATE LISTED HERE
Pharmacy Fax: (XXX) XXX - XXXX

To: PHARMACY NAME

From: Pharmacy Compliance Department
Sender's Phone: (470) 223-3580

Re: Notice of Intent to Audit

Cc: PDMI

☑ Urgent ☑ For Review ☐ Please Comment ☑ Please Reply ☐ Please Recycle

Comments:

ATTENTION PHARMACY MANAGER
PLEASE FIND ATTACHED LETTER REGARDING A DESK AUDIT BEING CONDUCTED ON BEHALF OF PDMI

Codoxo
3190 Northeast Expressway, NE, Suite 120, Atlanta, GA, 30341
Codoxo's Phone Number: +1-470-223-3580
Codoxo's Fax Number: +1-404-806-6275

DATE

Codoxo
3190 Northeast Expressway NE, Suite 120
Atlanta, GA, 30341
Codoxo's Phone Number: +1-470-223-3580
www.codoxo.com

Fax # of Pharmacy: (XXX) XXX-XXXX
NABP#: XXXXXXX
PHARMACY NAME
ADDRESS
CITY, STATE, ZIP

******* NOTICE OF RECORDS REQUEST *******

Dear Pharmacy Owner/Manager,

Pharmacy Data Management, Inc routinely performs audits of pharmacies within its provider networks to support its compliance and fraud, waste and abuse audit programs. PDMI has contracted with Codoxo, an authorized vendor of PDMI, to conduct desk audit reviews. Your pharmacy has been selected for a desk audit to be conducted by Codoxo.

As part of the audit process, for each prescription/claim on the attached list (below), please provide copies of the following:

- Photocopies - **FRONT AND BACK** – of original hard-copy prescriptions / physician order sheets (including back-slaps or any computer-generated stickers)
- Computerized dispensing records, including refill records
- Supporting documentation necessary to support the appropriateness and accuracy of the billing
- Compounding worksheet(s) with NDC #s and quantities of each ingredient billed
- Signature Logs

All documentation should be submitted to Codoxo via fax **within 30 days from the date of this letter.** Please include the **Records Transmittal Page** with the submission of your records to ensure proper handling and validation of the claims.

Failure or refusal to comply with an audit request may result in a full recovery of the total amount paid to the pharmacy for the claims involved in the audit review, including all amounts or fees paid to the pharmacy. Refusal or denial to comply with any audit type may result in corrective action up to and including termination of the pharmacy's Provider Agreement with Pharmacy Data Management, Inc.

If you have further questions or require additional information, please contact the Pharmacy Compliance Department, at 470-223-3580.
Sincerely,

Pharmacy Compliance Department
Cc: PDMI

RECORDS REQUEST REPORT

Please note: This audit contains 80 or fewer unique prescriptions. The claim count can exceed 80 claims due to refills.		
NABP	Rx Number	Fill Date
XXXXXXX	6856843	2020-01-28
XXXXXXX	6856843	2020-02-24
XXXXXXX	6856843	2020-03-23
XXXXXXX	6856843	2020-04-21

DATE

Dear Pharmacy Owner/Manager,

PDMI has authorized Codoxo, a fully HIPAA complaint pharmacy audit firm, to conduct routine audit function within the PDMI contracted pharmacy network.

PDMI greatly appreciates your shared commitment to quality healthcare for the people we serve and their communities.
Please accept this letter as our official authorization to allow Codoxo to conduct an audit of your Pharmacy on behalf of PDMI.

Sincerely,
PDMI
Pharmacy Audit Department

Record Transmittal
PLEASE RETURN THIS FORM WITH THE SUPPORTING DOCUMENTATION WITHIN 30 DAYS TO:

By E-Mail:	Rxcompliance@codoxo.com
By Fax:	(404) 806-6275
If you have any questions, please call:	(470) 223-3580

Frequently Asked Audit Questions

Q: What happens if a partial or illegible communication is received by the Pharmacy?

A: Include the Pharmacy's NABP/NCPDP or NPI and the Audit reference number (if legible) in the subject line of an email or fax cover page and describe any decipherable information on the letter and the issue.

Q: What type of documentation may be requested for a desktop audit?

A:

- A copy of the Letter of Intent to Audit
- Copy of the original prescription (front and back)
- Rx label: Copy of the label placed on the dispensed medication for the requested date of service
  *Copy of the signature log sheet (pickup or delivery) for verification and
- Manufacturer, wholesaler, or distribution invoices
- For compound audits: compound log if compounded medication
- For Long Term Care pharmacies, physician's order sheet for date of service or interim order Medication Administration Records (MAR) are not acceptable proof of the prescriber order.
- For vaccine audits: include the Vaccine Administration Record (VAR) if the prescription is for a vaccine

Q: How does the Pharmacy submit requested documentation?

A: Use the audit request letter or most recent letter as the cover page of audit response. Submit requested documentation.

Q: How do I address questions regarding an audit, including audit status?

A: Submit all questions and/or concerns in writing using bar coded audit letter to audit@pdmi.com.

Q: What happens if my initial audit response is not received?

A: Locate fax confirmation or email communication. Resubmit initial audit response along with fax confirmation or e-mail communications related to previous submission. Upon evaluation of documentation, audit will be placed back for initial review.

Q: How do I update the Pharmacy contact for audit communications?

A: Audit communications can be sent via email or fax. It is the Pharmacy's responsibility to

advise the Pharmacy Audits and Fraud, Waste, and Abuse and Network Compliance Departments of any change to the contact information on file.

Q: How do I appeal audit findings?

A: Refer to the above Audit Process and Procedures.

Q: Can I request an extension to respond to the audit or to appeal the initial audit findings?

A: Yes, refer to the above Audit Process and Procedures.

Q: Can I still appeal if the initial audit response was not submitted?

A: Refer to the above Audit Process and Procedures.

Q: Can my Pharmacy obtain a list with the prescriptions that will be reviewed during the onsite audit?

A: No, PDMI and its audit entities do not provide a list with the exact prescription numbers prior to the audit. This is part of the procedure to maintain the integrity of the onsite visit. However, a parameter of fill dates and prescription numbers may be provided in advance. Pharmacy will have opportunity to provide additional documentation during the appeal phase.

Q: What happens if the tracking number is too old to retrieve from the mail courier website?

A: Contact your account representative at the mail courier to provide date and time of successful delivery. Excel files with pertinent tracking information are acceptable if coming directly from the carrier account representative. Alternatively, a Patient attestation acknowledging delivery is acceptable; however, providing only a tracking number does not confirm Patient receipt.

Appendix A

Additional state specific requirements are listed below and will be followed.

Florida

Reimbursement remittance requirements (Fla. Stat. §626.8825(3)(a)-(b), (g))

At the time of adjudication for electronic claims or the time of reimbursement for nonelectronic claims, the pharmacy will be provided a remittance, including such detailed information as is necessary for the pharmacy or pharmacist to identify the reimbursement schedule for the specific network applicable to the claim and which is the basis used to calculate the amount of reimbursement paid. This information must include, but is not limited to, the applicable network reimbursement ID or plan ID as defined in the most current version of the NCPDP Telecommunication Standard Implementation Guide, or its nationally recognized successor industry guide.

Any basis of reimbursement information will be communicated to a pharmacy in accordance with the NCPDP Telecommunication Standard Implementation Guide, or its nationally recognized successor industry guide, when performing reconciliation for any effective rate guarantee, and that such basis of reimbursement information communicated is accurate, corresponds with the applicable network rate, and may be relied upon by the pharmacy.

Any Electronic Remittance Advice will contain claim level payment adjustments in accordance with the American National Standards Institute Accredited Standards Committee, X12 format, and include or is accompanied by the appropriate level of detail for the pharmacy to reconcile any debits or credits, including, but not limited to, pharmacy NCPDP or NPI identifier, date of service, prescription number, refill number, adjustment code, if applicable, and transaction amount.

Prohibitions of clawbacks, reconciliation offset and recoupments (Fla. Stat. §626.8825(3)(c))

There will be no financial clawbacks, reconciliation offsets, or offsets to adjudicated claims. The pharmacy will not be charged, withheld, or recouped direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when a fee may be recouped from a pharmacy, where applicable and pursuant to state law.

This prohibition does not apply to any incentive payments provided to a network pharmacy for meeting or exceeding predefined quality measures, such as Healthcare Effectiveness Data and Information Set measures; recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a pharmacy audit pursuant to s. 624.491. Additionally, the prohibition does not apply to any

recoupment that is returned to the state for programs in chapter 409 or the state group insurance program in s. 110.123.

Mail and Delivery Services (Fla. Stat. §626.8825(3)(e)

Unless otherwise prohibited by law, a pharmacy or pharmacist will not be prohibited from offering mail or delivery services on an opt-in basis at the sole discretion of the covered person, mailing or delivering a prescription drug to a covered person upon his or her request, or charging a shipping or handling fee to a covered person requesting a prescription drug be mailed or delivered if the pharmacy or pharmacist discloses to the covered person before the mailing or delivery the amount of the fee that will be charged and that the fee may not be reimbursable by the covered person's pharmacy benefits plan or program.

Fulfilling information requests from pharmacies (Fla. Stat. §626.8825(3)(f))

Upon request, a pharmacy will receive a list of plans or programs in which the pharmacy is a part of the network. Updates to the list will be communicated to the pharmacy within 7 days. The pharmacy or pharmacist is not restricted from disclosing this information to the public.

Administrative Appeal Process (Fla. Stat. §626.8825(3)(h))

There shall be a reasonable administrative appeal procedure to allow a pharmacy or pharmacist to challenge the maximum allowable cost pricing information and the reimbursement made under the maximum allowable cost as defined in s. 627.64741 for a specific drug as being below the acquisition cost available to the challenging pharmacy or pharmacist.

The administrative appeal procedure will include a telephone number and e-mail address, or a website, for the purpose of submitting the administrative appeal. The appeal may be submitted by the pharmacy or an agent of the pharmacy directly or through a pharmacy service administration organization. The pharmacy or pharmacist will be given at least 30 business days after a maximum allowable cost update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal. The administrative appeal will be responded to within 30 business days after receipt of the appeal.

If the appeal is upheld, the following will occur:

1. The maximum allowable cost pricing information will be updated to at least the acquisition cost available to the pharmacy;
2. Permit the pharmacy or pharmacist to reverse and rebill the claim in question;
3. Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and

4. Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable maximum allowable cost pricing information.

If the appeal is denied, the pharmacy or pharmacist will be provided the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state which have the drug currently in stock at a price below the maximum allowable cost pricing information.

Every 90 days, the total number of appeals received and denied in the preceding 90-day period will be reported to the office, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted pursuant to this paragraph.

Indiana

Contract Requirements (760 Ind. Admin. Code 5-4-1)

The pharmacy or the pharmacy services administrative organization will be given the right to obtain, within ten (10) calendar days after a request, a current list of the sources used to determine maximum allowable cost pricing. The maximum allowable cost list will be updated at least every seven (7) calendar days and contracted pharmacies and pharmacy services administrative organizations may promptly review maximum allowable cost list updates in a format that is readily available and accessible.

Audit Procedures (760 Ind. Admin. Code 5-3-3)

The following procedures will be followed when conducting an audit of the pharmacy:

1. For an onsite audit conducted at pharmacy's location, the auditor that conducts the audit will provide written notice to the pharmacy or pharmacist at least fourteen (14) calendar days before conducting the initial onsite audit for each audit cycle;
2. The auditor will not interfere with the delivery of pharmacist services to a patient, and must use every effort to minimize inconvenience and disruption to the pharmacy operations during the audit (although audits may be performed during normal business hours of pharmacy);
3. If the audit requires use of clinical or professional judgment, the audit shall be conducted by or in consultation with an individual licensed as a pharmacist under IC 25-26;
4. The auditor must allow the use of written or otherwise transmitted hospital, physician, or other health practitioner records to validate a pharmacy record;
5. The auditor must perform the audit according to the same standards and parameters that the auditor uses to audit all other similarly situated pharmacies;
6. The period covered by the audit must not exceed twenty-four (24) months after the date on which a claim that is the subject of the audit was submitted to or adjudicated (unless a longer period is required under federal or state law), and pharmacy will be permitted to resubmit electronically any claims disputed by the audit for a period of at least thirty (30) calendar days;

7. The auditor will not schedule an audit to begin during the first seven (7) calendar days of a month without the voluntary consent of the pharmacy;
8. Payment to the auditor for conducting the audit will not be based on a percentage of the amount recovered as a result of the audit;
9. Within twenty-four (24) hours of receiving the notice of an audit, the pharmacy may reschedule the audit to a date not more than fourteen (14) calendar days after the date proposed by the auditor (although if the auditor is unable to reschedule within the fourteen (14) calendar day period, the auditor must select and reschedule the audit for a date after the fourteen (14) calendar day period); and
10. The auditor must allow the pharmacy or pharmacist to produce documentation to address a discrepancy found during the audit.

Nebraska

Contract Requirements; Prohibited Acts; Disclosure of Information (Neb. Rev. Stat. § 44-4606)

The Agreement between pharmacy and Company will not prohibit or restrict the pharmacy or any pharmacist, or penalize any pharmacy or pharmacist for, disclosing any health care information that pharmacy or pharmacist deems appropriate regarding:

1. The nature of treatment, risks, or an alternative to such treatment;
2. The availability of an alternative therapy, consultation, or test;
3. The decision of a utilization review or similar person to authorize or deny a service;
4. The process that is used to authorize or deny a health care service or benefit; or
5. Information on any financial incentive or structure used by the health carrier.

The pharmacy or pharmacist will not be prohibited from discussing information regarding to the total cost for a pharmacist service for a prescription drug or from selling a more affordable alternative if a more affordable alternative is available.

Company will not prohibit, restrict, or limit disclosure of information to the Director of the Insurance Department, law enforcement, or a state or federal governmental official, provided that: (a) The recipient of the information represents that such recipient has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and (b) Prior to disclosure of information designated as confidential, the pharmacist or pharmacy marks as confidential any document in which the information appears, or requests confidential treatment for any oral communication of the information.

Company will not terminate the contract with or penalize a pharmacist or pharmacy due to the pharmacist or pharmacy: (a) Disclosing information about a Company practice, except information determined to be a trade secret, as determined by state law or the director; or (b) Sharing any portion

of the Agreement with the Director pursuant to a complaint or a query regarding whether the Agreement is in compliance with the Pharmacy Benefit Manager Licensure and Regulation Act.

Company will not require a patient to pay an amount greater than the lesser of the patient's cost-sharing amount under the terms of the health benefit plan or the amount the patient would pay for the drug if the patient were paying the cash price. Any such amount paid by a patient shall be attributable toward any deductible or, to the extent consistent with section 2707 of the federal Public Health Service Act, 42 U.S.C. 300gg-6, as such section existed on January 1, 2022, the annual out-of-pocket maximum under the covered person's health benefit plan.

Pharmacy Audits (Neb. Rev. Stat. § 44-4607)

Unless otherwise prohibited by federal law, an auditing entity conducting a pharmacy audit will: (a) Give pharmacy notice fifteen business days prior to conducting an initial onsite audit; (b) For any audit that involves clinical or professional judgment, conduct such audit by or in consultation with a pharmacist; and (c) Audit pharmacy under the same standards and parameters as other similarly situated pharmacies.

Unless otherwise prohibited by federal law, for any Pharmacy audit conducted by an auditing entity:

(a) The period covered by the audit shall not exceed twenty-four months from the date that the claim was submitted to the auditing entity, unless a longer period is required under state or federal law;

(b) If an auditing entity uses random sampling as a method for selecting a set of claims for examination, the sample size shall be appropriate for a statistically reliable sample;

(c) The auditing entity shall provide pharmacy a masked list containing any prescription number or date range that the auditing entity is seeking to audit;

(d) No onsite audit shall take place during the first five business days of the month without the consent of the pharmacy;

(e) No auditor shall enter the area of pharmacy where patient-specific information is available without being escorted by an employee of pharmacy and, to the extent possible, each auditor shall remain out of the sight and hearing range of any pharmacy customer;

(f) No recoupment shall be deducted from or applied against a future remittance until after the appeal process is complete and both parties receive the results of the final audit;

(g) Company will not require information to be written on a prescription unless such information is required to be written on the prescription by state or federal law;

(h) Recoupment may be assessed for information not written on a prescription if:

(a) Such information is required by Company or the information is required by the federal Food and Drug Administration or the drug manufacturer's product safety program; and

(b) The information required is not readily available for the auditing entity at the time of the audit; and

(i) No auditing entity or agent shall receive payment based on a percentage of any recoupment.

For recoupment under the Pharmacy Benefit Manager Licensure and Regulation Act, the auditing entity shall:

a. Include consumer-oriented parameters based on manufacturer listings in the audit parameters;

b. Consider the pharmacy's usual and customary price for a compounded medication as the reimbursable cost, unless the pricing method is outlined in the Agreement;

c. Base a finding of overpayment or underpayment on the actual overpayment or underpayment and not a projection that relies on the number of patients served who have a similar diagnosis, the number of similar orders, or the number of refills for similar drugs;

d. Not use extrapolation to calculate the recoupment or penalties unless required by state or federal law;

e. Not include a dispensing fee in the calculation of an overpayment, unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by pharmacy, or the identified overpayment is solely based on an extra dispensing fee;

f. Not consider as fraud any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record. Such error may be subject to recoupment;

g. Not assess any recoupment in the case of an error that has no actual financial harm to the covered person or health benefit plan. An error that is the result of pharmacy failing to comply with a formal corrective action plan may be subject to recoupment; and

h. Not allow interest to accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

To validate a pharmacy record and the delivery of a pharmacy service, the pharmacy may use an authentic and verifiable statement or record, including a medication administration record of a nursing home, assisted-living facility, hospital, physician, or other authorized practitioner or an additional audit documentation parameter located in the Provider Manual. Any legal prescription may be used to validate a claim in connection with a prescription, refill, or change in a prescription, including a medication administration record, fax, e-prescription, or documented telephone call from the prescriber to the prescriber's agent.

The auditing entity conducting the audit shall establish a written appeal process which shall include procedures for appealing both a preliminary audit report and a final audit report. A preliminary audit report shall be delivered to pharmacy within one hundred twenty days after the conclusion of

the audit. Pharmacy will be allowed at least thirty days following receipt of a preliminary audit report to provide documentation to address any discrepancy found in the audit. A final audit report will be delivered to the pharmacy within one hundred twenty days after receipt of the preliminary audit report or the appeal process has been exhausted, whichever is later. An auditing entity will remit any money due to the pharmacy or pharmacist as the result of an underpayment of a claim within forty-five days after the appeal process has been exhausted and the final audit report has been issued.

These requirements do not apply to any investigative audit that involves suspected fraud, willful misrepresentation, or abuse, or any audit completed by a state-funded health care program.

Maximum Allowable Cost Lists (Neb. Rev. Stat. § 44-4608)

The maximum allowable cost price list will be updated at least every seven business days, noting any price change from the previous list, and provide a means by which the pharmacy may promptly review a current price in an electronic, print, or telephonic format within one business day of any such change at no cost to the pharmacy. A procedure will be maintained to eliminate a product from the maximum allowable cost price list in a timely manner to remain consistent with any change in the marketplace. The maximum allowable cost price list will be available to the pharmacy in a format that is readily accessible and usable to the pharmacy.

A prescription drug will not be placed on a maximum allowable cost price list unless the drug is available for purchase by pharmacies in Nebraska from a national or regional drug wholesaler and is not obsolete.

There is a process to appeal, investigate, and resolve disputes regarding any maximum allowable cost price. The pharmacy has a fifteen-business-day limit on the right to appeal following submission of an initial claim by the pharmacy. Any appeal will be investigated and resolved within seven business days after the appeal is received. The pharmacy will be provided a reason for any denial of an appeal and identify the national drug code for the drug that may be purchased by pharmacy at a price at or below the price on the maximum allowable cost price list.

If an appeal is determined to be valid the drug price will be adjusted no later than one day after the appeal is resolved and the pharmacy will be permitted to reverse and rebill the claim in question, using the date of the original claim.

340B Prohibitions (Neb. Rev. Stat. § 44-4609)

To the extent that the pharmacy is a 340B contract pharmacy, the pharmacy will not be reimbursed for pharmacy-dispensed drug that is subject to an agreement under 42 U.S.C. 256b at a rate lower than that paid for the same drug to similarly situated pharmacies that are not 340B contract pharmacies, and will not be assessed any fee, chargeback, or other adjustment on the basis that the pharmacy participates in the program set forth in 42 U.S.C. 256b.

The pharmacy will not be discriminated against in a manner that prevents or interferes with a covered individual's choice to receive such drug from a 340B covered entity or from the pharmacy as a 340B contract pharmacy.