SHARE A CLEAR VIEW

NAVITUS
HEALTH SOLUTIONS

PHARMACY PROVIDER
MANUAL

Version 8.08062012

PH-0812-015
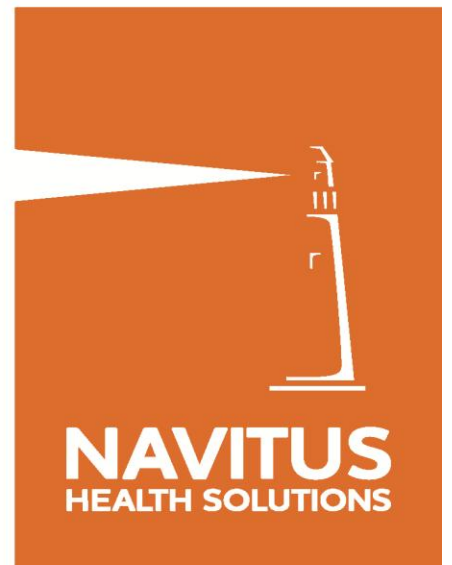
Navitus Health Solutions is a 100 percent pass-through pharmacy benefit company committed to lowering drug costs, improving health and providing superior customer service in a manner that instills trust and confidence.

Our Mission

Navitus Health Solutions LLC is a pharmacy benefit company committed to lowering drug costs, improving health and providing superior customer service in a manner that instills trust and confidence.

Lowering Drug Costs

Through Navitus' completely transparent business model, all hidden costs associated with the purchase of prescription drugs are eliminated. We negotiate discounts and rebates with drug manufacturers and contract with pharmacies on behalf of plan sponsors--enabling us to pass 100 percent of savings onto our plan sponsors.

Improving Health

In addition, by ensuring formulary development and quality improvement decisions are reviewed and approved by prescribers and pharmacists, Navitus provides the highest quality pharmaceutical care to our members.

Superior Customer Service

At Navitus, we offer a wide variety of pharmacy benefit management services, including benefit design and consulting, formulary management, pharmacy network management and clinical programs. All efforts are developed and implemented with our members' best interests in mind.

TABLE OF CONTENTS

IMPORTANT CONTACT INFORMATION

To receive the best service possible, please contact the appropriate call center.

Commercial Navitus Pharmacy Help Desk 24/7*... 866 333-2757 (toll-free)

Website: www.navitus.com

Medicare D Navitus Pharmacy Help Desk 24/7 .... 866-270-3877 (toll-free)

Website: www.medicarerx.navitus.com

Texas Medicaid/CHIP Pharmacy Help Desk 24/7* .... 877-908-6023 (toll-free)

Pharmacy Provider Relations/Contracts...608-729-1577

E-mail: providerrelations@navitus.com .... 920-735-5351(fax)

ELECTRONIC REMITTANCE AND PAYMENT ISSUES

MAC Pricing Inquiries or Issues 608-729-1577

Compliance and Audit Department 920-225-7016

To report, Fraud, Waste and Abuse contact (866)-333-2757, ext. 7041 or 920-225-7041

*Closed 6 a.m. Thanksgiving Day – 6 a.m. Friday after Thanksgiving and closed 6 p.m. Christmas Eve- 6 a.m. the day after Christmas.

PHARMACY RIGHTS AND RESPONSIBILITIES

RIGHTS

- To be treated with respect and dignity
- To receive prompt and courteous responses to inquiries directed to Navitus
- To receive timely communications from Navitus on items affecting pharmacy services
- To expect reimbursement in a timely fashion for covered drug products and services
- To express a complaint and receive a response within a reasonable amount of time
- To expect confidentiality of business and credentialing documents

RESPONSIBILITIES

- Comply with laws and provide services in a manner compliant with the highest standards
- Maintain the confidentiality of Members in accordance with HIPAA privacy laws
- Maintain facility and equipment in first-class condition
- Provide annual training for staff to mitigate fraud, waste and abuse
- Maintain all materials relating to pricing, contracts, programs, services, and business practices of Navitus as proprietary and confidential
- Maintain and enforce comprehensive policies and procedures for operation
- Non-discrimination against Members
- Fill prescriptions according to the Prescriber's directions
- Coordinate with the prescribing physician
- Assure the authenticity of the Prescription Drug Order
- Seek to prevent Prescription Drug Orders from being filled by multiple pharmacies
- Ensure reasonable verification of the identity of the patient, prescriber and if appropriate, caregiver
- Dispense preferred formulary products for non-preferred products, wherever possible and adhere to the Formulary and Preferred Drug List (PDL for Texas Medicaid)
- Obtain and maintain patient medication profiles
- Ensure Members receive all medications for which they were eligible
- Coordination of benefits when a Member also receives Medicare Part D services or other insurance benefits
- Maintain, for a minimum of ten years from the date of service, complete records related to:
  - Original prescriptions

- o Prescriber information
- o Signature and/or electronic tracking logs
- o Refill information
- o Patient profiles
- o Wholesaler, manufacturer and distributor invoices

- Display all DUR alerts to the dispensing pharmacist; respond to all online edits
- Take appropriate action regarding suspected adverse drug reactions and errors
- Inform patients or caregivers about drug recalls
- Educate consumers and caregivers about the appropriate means to dispose of expired, damaged, and unstable medications
- Assure that medications and devices are maintained within appropriate temperature, light, and humidity standards during storage and shipment
- Provide instructions to the patient on storage, dosing, side effects, potential interactions, and use of medication dispensed in accordance with professional practice guidelines
- Collect from each Member the applicable copayment or coinsurance
- Submit claims electronically, at the point-of-sale, only for the patient for whom the prescription was written by the Prescriber.
- Utilize accurate National Provider Identifier (NPI) in the correct NCPDP data field
- Reverse claims for product returned to stock within 14 days of the original service date
- Maintain prescription error prevention measures and maintain an incident record of all actual and potential injuries due to dispensing errors
- Notify Navitus within five days of any status change in Pharmacy or Pharmacist license
- Notify NCPDP of all changes regarding demographic changes, opening or closing of a pharmacy, and changes in location in a timely manner.
- A dispensing pharmacist is under no obligation to dispense a prescription, which, in his/her professional opinion, should not be dispensed.
- Always maintain credentials, and provide credentials to Navitus on a periodic basis as requested.

NAVITUS CUSTOMER CARE RESPONSIBILITIES

The cornerstone of Navitus Customer Care is consistent, knowledgeable and timely responses delivered with a personal touch. We strive to resolve each call correctly, completely, and professionally the first time. Our relentless pursuit of superior customer service is what sets us apart from our competitors. Navitus Health Solutions Customer Care:

Our Customer Care Commitment to our Network Pharmacies:

- We will be **responsive** to our customer's needs.
- We will be **respectful** of our customers at all times.
- We will be **realistic** about what we can or cannot do.
- We will **resolve** our customer's issues in a timely fashion.
- We will take personal **responsibility** for our customer relationships.

Navitus has teams of multidisciplinary individuals available to assist Participating Pharmacies with the coordination of day-to-day functions.

Pharmacy Provider Relations Department

The Navitus Network Department hours of operations are Monday through Friday 8:30 am – 5:00 pm CST. We are available to assist you with:

- Credentialing/Contracts
- Orientation
- Reimbursement / Network set-up
- MAC pricing
- General feedback regarding Navitus' performance

Contact us at: providerrelations@navitus.com or call (608) 729-1577

Pharmacy Help Desk

Navitus pharmacy help desks are available to assist you with:

- Member Plan, group and benefits information
- Member eligibility
- Formulary questions
- Prior authorization processes
- Claims processing issues
- Billing / payment inquiries
- Dispute and appeals process

CLAIMS ADJUDICATION

All Participating Pharmacies must comply with NCPDP standard transactions for pharmacy drug claims, coordination of benefits and related pharmacy services.

DOWN-TIME PROCEDURES

Navitus Health Solutions attempts to minimize planned adjudication down-time and to correct unexpected down-time issues as quickly as possible. In the rare event of an unexpected down-time or in the event of planned down-time, we ask that our Network Pharmacies attempt to service our Members with minimal disruption. Navitus Customer Care is available to assist pharmacies with maintaining business operations during adjudication down-time.

We ask that our Network Pharmacy dispense the necessary medication, receive the applicable patient pay amount, and submit electronically when possible. When online submission is not possible, call the appropriate call center listed on page 1 for assistance with:

- Confirming eligibility
- Verifying coverage
- Copay information
- Expected time claims processing will resume

REVERSALS

- Pharmacies are required to complete reversals within the same payment cycle as the submission or up to 14 days after the claim was adjudicated for prescriptions that have not been picked up by member.
- Failure to reverse appropriate claims may result in an audit recovery and recapture of all costs involved in the reversal.
- If unable to reverse a claim online, contact the appropriate call center listed on page 5 for assistance.

Required Fields
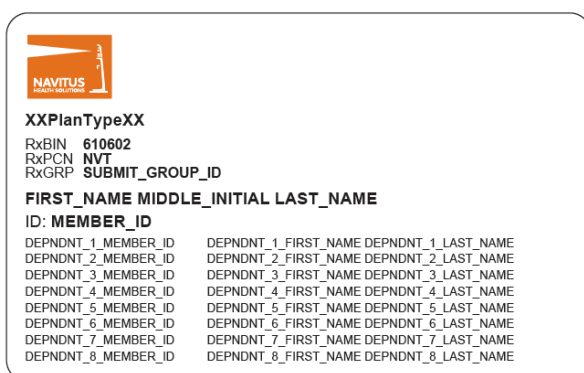
Minimum Required fields when submitting claims: See payer sheets at www.navitus.com > Pharmacies > Pharmacies Login for complete listing of NCPDP field requirements.

- BIN: 610602 (from ID Card)
- PCN: (from ID Card- can vary by payer)
- Group (from ID Card-can vary by payer)
- Member ID: (Length, person code, card layout can vary by payer)
- Date of Birth
- Gender
- Relationship Code
- U&C

Member ID Helpful Information:

- Navitus Member benefit cards may vary by payer; Navitus also may produce separate pharmacy or combination medical/pharmacy benefit cards for clients.
- When using a Navitus ID Card, submit the number indicated by "ID" for the subscriber.
- Each dependent may have his or her own ID number next to his or her name.
- The ID field length also varies by payer.
- If the ID is unable to find a Member match, the claim rejects "Non-matched Cardholder ID"
- If the ID is not the correct length, claim rejects "M/I ID Length"
- The applicable Pharmacy Help Desk phone number is printed on the back of the members ID card

Sample Navitus Member ID Card (note: many Navitus payers produce their own ID cards)

REQUIRED IDENTIFICATION NUMBERS

National Provider Identifier (NPI) is the required Pharmacy and Prescriber identifier by the Health Insurance Portability and Accountability Act of 1996 replacing legacy identifiers (ie: NABP number, DEA) on all electronically transmitted claims into Navitus. The NPI is a unique 10-digit identifier assigned to healthcare providers, such as Prescribers and Pharmacies, to use when submitting a HIPAA standard transaction. Navitus requires the use of NPI in transactions.

Pharmacy NPI field must submit correct NPI is required to submit their NPI in NCPDP field 201-B1 (Service Provider ID) with the qualifier "01" in NCPDP field 202-B2 (Service Provider ID Qualifier).

Prescriber NPI field- is required to submit accurate information identifying the Prescriber for each claim submitted. Prescriber NPI must be submitted in NCPDP field 444-E9 (provider ID) along with the qualifier "01" in the NCPDP field 465-EY (Provider ID qualifier).

COMPOUNDED PRESCRIPTIONS

- A compound consists of two or more ingredients, one of which must be a formulary Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order.
- The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality, and purity, with appropriate packaging and labeling in accordance with good compounding practices.
- For Navitus to cover a compound, all active ingredients must be covered on the patient's formulary. In general, drugs used in a compound follow the member's formulary as if each drug components were being dispensed individually. The Payer must include Compound Drugs as a covered benefit for the Member for Navitus to allow reimbursement.
- Any compounded prescription ingredient that is not approved by the FDA (e.g. Estriol) is considered a non-covered product and will not be eligible for reimbursement.
- Please contact the appropriate call center listed on page 5 to see if a Client allows for compound prescriptions.

Processing Compound Prescriptions

- Navitus uses a combination of the claims, compound and DUR segment to fully adjudicate a compound prescription. Use the Compound Code of 02 (NCPDP field 406-D6 located in Claim Segment on payer sheet) when submitting compound claims

- The claim must include an NDC for each ingredient within the Compound Prescription with a minimum of 2 NDCs and a maximum of 25 NDCs (NCDPD field 447-EC located in Compound Segment

- The claim must include a qualifier of "03" (NDC) to be populate in NCPDP field 448-RE followed by NCPDP field 489-TE (NDC's).

- If an NDC for a non-covered drug is submitted, the claim will be denied.

- If the pharmacy will accept non-payment for the ingredient, submit an "8" in the Clarification Code Field (420-DK located on the D.0 Claim Segment Field)

- This will allow the claim to pay and the pharmacy will be reimbursed for all drugs except the rejected medication with Clarification Code of 8.

- For many Navitus payers, compounds with a cost exceeding $200 must receive an approved prior authorization from Navitus for coverage to be considered. Forms are available on www.navitus.com.

- If a compound includes a drug that requires prior authorization under the member's plan, the prior authorization must be approved before the compound is submitted.

- Compound Claims forms are available at www.navitus.com and in the Appendix of this document.

- Submit the minutes spent compounding the prescription for reimbursement. The minutes listed are to be populated within NCPDP D.0 Field 474-8E (level of effort- DUR segment).

Compound Preparation Time	Value	Reimbursement Amount
1 – 5 Minutes	**11**	$10.00
6 – 15 Minutes	**12**	$15.00
16 – 30 Minutes	**13**	$20.00
31+ Minutes	**14**	$25.00

Example of the NCPDP D.0 fields for submitting a compound claim:

45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR
452-EH	COMPOUND ROUTE OF ADMINISTRATION
447-EC	COMPOUND INGREDIENT COMPONENT COUNT
488-RE	COMPOUND PRODUCT ID QUALIFIER
489-TE	COMPOUND PRODUCT ID
448-ED	COMPOUND INGREDIENT QUANTITY
449-EE	COMPOUND INGREDIENT DRUG COST
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION
474-8E	DUR/PPS LEVEL OF EFFORT

DISPENSE AS WRITTEN (DAW) CODES

- Prescriptions with a DAW request must indicate the DAW code NCPDP field 408-D8 (also known as Product Selection Code) on the submitted claim.
- Prescriptions indicated as "Dispense as Written (DAW)" or "Brand Necessary" by the Prescriber, or requested by the patient (where allowed by law), must be noted on the actual prescription.
- Cost-sharing varies by client. Contact the appropriate call center listed on page 5 with questions.

ADDITIONAL OR REPLACEMENT DRUGS

Allowances for travel medication and/or replacement of lost, stolen, or forgotten medication varies by client benefit design. Please contact the appropriate call center listed on page 5 to obtain individual member benefit information.

CLAIM PRICING AND PAYMENT

MAC PRICING ISSUES

Navitus produces its own proprietary MAC list and corresponding unit costs on behalf of our clients. The unit costs are ascertained from information from many sources, including CMS FUL, published MACs, wholesaler supplied information, pharmacy supplied information, and other sources. The Navitus MAC is a pass-through MAC whereby the pharmacy reimbursement is the same as the client invoice on claims.

If you experience negative reimbursement for a drug on our MAC list, please complete and fax us a Navitus Pricing Research Request Form for our review. The NDC in question must be from your primary wholesaler to be eligible for consideration. All relevant information must be provided including a copy of your wholesaler invoice that lists the net acquisition cost of the product. To access the form, use the link provided below, refer to the form in the Appendix, or contact a Navitus Pharmacy Help Desk. Please note that Navitus does NOT guarantee that all claims produce a positive margin. Navitus will evaluate information provided to it, however Navitus is not obligated to adjust any claim or make changes to the pharmacy reimbursement or the MAC list.

https://www.navitus.com/Document%20Library/NavitusPricingResearchRequestForm.pdf

Instructions:

1. Complete pharmacy information
2. Complete the claim information or attach a copy of the claim if it contains key information
3. Provide proof of acquisition price. Include all discounts and chargebacks to provide us with your true acquisition cost for the product.
4. Please list your wholesaler in comments section

   - We will respond via phone or in writing within 10 business days after receiving your request.
   - If the NDC is approved for adjusted pricing, you can reprocess within 10 business days.
   - If the NDC price is adjusted, the effective date would be for the fill date on the MAC Form.
   - For future use, complete your pharmacy's information and photocopy the form. You may then attach a copy of the claim with the copied form (if it contains all necessary information).

PAYMENT CYCLES

Pharmacy Reimbursement Payment Cycle

Navitus' standard pharmacy payment cycle is twice monthly, unless required by Federal or State law for an alternative payment frequency.

- Date of fill 1st thru 15th: payable within 30 days
- Date of fill 16th thru last day of month: payable within 30 days

Pharmacy Reimbursement Payment Cycle for Medicare Part D and Medicare Advantage correspond with CMS guidelines of no more than 14 days.

REMITTANCE

- Navitus offers electronic ASC X12 5010 835 remittances as well as paper remittances.
- Electronic remittances may be accessed through our secured FTP server.
- If you are interested in receiving electronic remits, complete the 835 Request Form (see Addendum or www.navitus.com > Pharmacies > Pharmacies Login).
- Fax the completed form to Navitus using the number on the form.
- Allow 21 business days for setup. Navitus does place test files on the FTP server to assure a smooth transition for your pharmacy(s).
- Navitus reserves the right to charge an additional fee to recreate an 835 file or create a CD.
- Claims denied through the online adjudication system do not appear on the Remittance Advice.
- All payees requesting electronic remittances for Medicare Part D reimbursement will be required to accept electron 835 remittances

DRUG INFORMATION SOURCE

- Navitus receives drug information from Medi-Span and updates its system files on a weekly basis.
- The AWP and Wholesale Acquisition Cost (WAC) information, if published, used in determining pharmacy reimbursement are updated weekly from Medispan
  - In the rare instance where Medispan does not publish an AWP or WAC price, Navitus will determine the price from other sources, including but not limited to direct published prices or a percentage calculation between AWP and WAC.

CLINICAL PROGRAMS

Our commitment to complete clinical and operational transparency - for members, plan sponsors, and contract pharmacies - means more than revealing network pharmacy discounts and drug manufacturer rebates. All Navitus clinical management programs and services are evidence-based and adhere to stringent HIPAA-compliant guidelines. We have included some information about our programs below. If you would like more information on clinical programs, contact the appropriate call center listed on page 5.

PRIOR AUTHORIZATION

Prior authorization requires the Prescriber to receive pre-approval for coverage of select drugs under the terms of the Navitus client pharmacy benefit plan. The purpose of the Prior Authorization Program is to:

- Increase appropriate utilization of certain drugs
- Promote treatment or step-therapy protocols
- Actively "risk manage" drugs with serious side effects
- Positively influence the process of managing drug costs

For commercial and Medicare Part D, If you receive a rejection message of "*70- Drug Not Covered*" or "*75- Prior Authorization Required,*" the physician can request a Prior Authorization form to be faxed to them or you can download the form from www.navitus.com > Pharmacies > Pharmacies Login. Please note that the Prior Authorization forms pertain to Navitus commercial and Medicare Part D business only.

Non-Urgent Prior Authorization Requests

- Prescriber or pharmacy requests correct form or accesses the form on www.navitus.com.
- Prescriber completes and faxes the completed request to the number listed on the form.
- A decision will be rendered within the timeframe indicated on the form after receiving complete information.
- If additional information is needed, the Prescriber will be contacted.
- If complete information is not received within the required timeframe, the request will be denied.
- If the request is approved, Navitus will send a letter to the Member.

- If the request is denied, Navitus will fax the Prescriber and send a letter to the Member.

Urgent (Life Threatening) Requests

- Prescriber requests or obtains the applicable clinical Prior Authorization form from www.navitus.com.
- Prescriber should contact the member's Customer Care as notification that an urgent request has been submitted.
- Prescriber will be notified of the decision within 24 hours.

PHARMACEUTICAL CARE INCENTIVES

The Pharmaceutical Care Incentive Program (PCI) reimburses pharmacists for a portion of their time spent counseling patients. Through online adjudication of PCI claim codes, pharmacists are able to indicate PCI participation per counsel conducted and submit for reimbursement. See Patient Training form or Clinical Services form at the end of this handbook.

Qualifying Services Information

Formulary Interchange: Changing a non-formulary drug to a formulary drug. Prescriber contact and authorization is required. Qualifying examples include:

- Drugs not yet reviewed by the Navitus Pharmacy & Therapeutics (P&T) Committee are non-formulary; Formulary alternatives are available by calling Customer Care or by visiting www.navitus.com.
- Switching a patient from a Tier 3 drug to a Tier 1 or 2 drug that does not require prior authorization.
- Switching a patient from a non-covered drug to a covered one that does not require prior authorization.

Therapeutic Interchange: Making a change in a patient's prescription order to a more cost-effective option. Physician contact and authorization is required. Qualifying examples include:

- Switching a drug requiring prior authorization to a therapeutically equivalent agent that does not require prior authorization (e.g. Switching Lyrica for gabapentin or a TCA).
- Switching a brand for a generic (e.g. lisinopril for Altace). An A-rated generic does not qualify.

- Changing the strength and quantity of a tablet-splittable drug to a configuration that makes the same drug splittable (e.g. Crestor 20mg 1 tab qd to 40mg tab ½ tab qd).
- Discontinuing a medication the patient no longer requires (e.g. PPI 2 months after initiation).
- Discontinuing a drug causing the patient an adverse effect and replacing it with a safer alternative (e.g. stopping metformin in a renally impaired patient).

Change of Dose: When the prescribed dose is higher or lower than recommended; dose requires adjustment due to renal or hepatic dysfunction; adjustment required due to interacting medication (inhibitor or inducer); or duration is insufficient or excessive. This requires the prescription to be changed and authorized by the Prescriber. Qualifying activities include:

- Lowering the dose according to renal function.
- Increasing dose when optimal therapeutic effect is not yet attained (e.g. target dosing).
- Discontinuing a drug for which the patient is already receiving a therapeutic equivalent.
- Lowering the dose of a medication for which an inhibitor is concomitantly being used.
- Discontinuing a medication due to contraindication in hepatic or renal dysfunction or in the presence of a severe-rated interacting medication.

Patient Compliance Monitoring: Identification of patients with less than a 70 percent compliance rate as determined by any one of the following approaches:

- Days supply dispensed (not to include today) / Total days between the last 2 fills

OR

- Patients regularly filling prescriptions > 10 days early or later than expected

OR

- Patient regularly asking for refills of medicines for reasons that include it being lost or stolen

OR

- Patients given a prescription for oral corticosteroids because of an asthma exacerbation

Qualifying Activities Include:

- Follow-up telephone call to the patient 3-4 days after dispensing an acute antibiotic prescription to assess efficacy and tolerability and emphasizing adherence to treatment.
- Identifying and correcting reasons for late fills and communicating this with the prescriber.

- Assessing and implementing a medication organization plan that may or may not include a pill organizer, unit dose packaging or other adherence enhancing tools (the specific tool is not reimbursable). Communication of the plan to the prescriber is necessary.

- Assessment, identification and addressing specific adherence barriers and approaches to overcome barriers. Such barriers can include cost (switching drug to a lower-cost alternative), refill reminders, transportation issues (mail order or delivery services), and recruiting a reliable and willing caregiver to assist in the adherence plan.

- Confirming patients with asthma exacerbations have an active prescription for an inhaled corticosteroid (ICS), are currently using the ICS during the exacerbation period, and exhibit proper inhalation technique for the ICS. A follow-up phone call within 2-4 days post dispensing of the OCS to determine status and communication of this status to the primary care physician and/or allergist of record is necessary.

Pharmacy Care Incentives - Reimbursement Rates

Participation in this program may vary by Navitus client. Reimbursement rates are subject to change.

Pharmacist Intervention	NDC Entered	Quantity Dispensed Value	Reimbursement Rate	Notes
Formulary Interchange	99999-9999-32	1	$4/ prescription	• See qualifying activities • Can combine with *Patient Compliance Monitoring* if applicable
Therapeutic Interchange	99999-9999-33	1	$12/ prescription	• See qualifying activities • Can combine with *Patient Compliance Monitoring* if applicable
Change in Dose	99999-9999-34	1	$5/ prescription	• See qualifying activities • Can combine with *Formulary Interchange* or *Therapeutic Interchange* if applicable
Patient Compliance Monitoring	99999-9999-35	1	$10/ prescription or encounter	• See qualifying activities • Can combine with *Change in Dose* or *Therapeutic Interchange* if applicable

Pharmacist Intervention	NDC Entered	Quantity Dispensed Value	Reimbursement Rate	Notes
Patient Training- Glucose Monitors	99999-9999-36	Up to 30	$1/minute	
Patient Training- Asthma Inhaler/ Peak Flow Meter	99999-9999-37	Up to 10	$1/minute	
Patient Training- Blood Pressure Monitors	99999-9999-38	Up to 15	$1/minute	
Patient Training- Nasal Inhalers	99999-9999-39	Up to 5	$1/minute	

Pharmacy Care Incentives- Reference Sheet

Participation in this program may vary by Navitus client. Reimbursement rates are subject to change.

Formulary Interchange

NDC Number: 99999-9999-32   Submit quantity of 1

Reimbursement: $4

Use when a prescription for a medication not on the formulary is changed to a formulary medication. Do not submit if prescriber authorized a medical exception or obtained prior authorization.

Therapeutic Interchange

NDC Number: 99999-9999-33   Submit quantity of 1

Reimbursement: $12

Use when changing a patient's prescription to a more cost-effective option. Requires notification of the prescriber and change in prescription. Brand to an A-rated generic not reimbursable.

Change of Dose- RxCents or Dose Consolidation

NDC Number: 99999-9999-34   Submit quantity of 1

Reimbursement: $5

Use when the prescribed dose is higher or lower than the recommended dose or the duration is insufficient or excessive. Requires a prescription change by the prescriber. Do not submit if the prescriber omits essential information such as the strength of medication.

Patient Compliance Monitoring

NDC Number: 99999-9999-35   Submit quantity of 1

Reimbursement: $10

Use when a pharmacist educates the patient on the importance of taking medication regularly and notifies the prescriber that the patient is less than 70 percent compliant over the past three months.

Patient Training on Glucose Monitors

NDC Number: 99999-9999-36   Submit number of minutes as the quantity

Reimbursement: $1 per minute, up to 30 minutes

Patient Training on Asthma Inhaler/Peak Flow Meter

NDC Number: 99999-9999-37   Submit number of minutes as the quantity

Reimbursement: $1 per minute, up to 10 minutes

Patient Training on Blood Pressure Monitors

NDC Number: 99999-9999-38   Submit number of minutes as the quantity.

Reimbursement: $1 per minute, up to 15 minutes

Patient Training on Nasal Inhalers

NDC Number: 99999-9999-39   Submit number of minutes as the quantity

Reimbursement: $1 per minute, up to five minutes

SUBMITTING PHARMACEUTICAL CARE INCENTIVE CLAIMS

General Information

- A patient can undergo more than one intervention at the point-of-service such as multiple interventions in the same category or interventions from multiple categories.
- Interventions can be submitted at any time but the actual date the care was provided needs to be the date submitted.
- Reimbursement for PCI will be included in the normal pharmacy payment cycle.
- The patient must sign the hard copy of the intervention documentation form. File documents in a secure location (locked file cabinet or equivalent). On the original prescription relating to the intervention, mark or indicate the prescription underwent a pharmacist intervention.

PCI claims are submitted online as any prescription using the following fields and guidance:

- <u>Patient Name:</u> Submit a claim under the patient for which the intervention was performed.
- <u>Prescriber:</u> If the prescription was changed, use the prescriber who authorized the change.
  - *Patient Compliance Monitoring-* submit the prescriber notified of the compliance issue.
  - *Device education-* use the prescriber who authorized the prescription.
- <u>Date of Care:</u> Use the actual date the intervention was performed.
- <u>NDC Number:</u> Use the NDC that corresponds to the intervention performed (see Reference Chart).

GENERIC COPAY WAIVER

The Generic Copay Waiver Program encourages Prescribers to prescribe to Navitus Members certain generic medications as an alternative to using high-cost, brand name medications by reducing or waiving the Members' generic copayment for the product. Participation in this program may vary by Navitus payer.

How it Works

- Prescribers write a prescription for a qualifying generic medication
- For the first fill, Members will have no copay

Medications included in the Navitus Generic Copay Waiver Program are indicated with "GW" on the drug formulary that you can access at www.navitus.com > Pharmacies > Pharmacies Login. A Member switching from the brand to an A-rated drug does not qualify

- This program applies only to Payers that choose to incorporate it within the Plan Specification.

NAVITUS SPECIALTY PHARMACY

Some Navitus payers benefit plans include a mandatory specialty program that requires the use of certain Specialty Pharmacy providers to obtain specialty medications. If you receive a reject code of 70 and message "PM excludes; required through Specialty Pharmacy, please refer to phone number Navitus returns at point of sale for medications that require the use of the Navitus specialty pharmacy."

Specialty drugs are typically higher priced medications that require additional clinical management and oversight to ensure efficacy and appropriate use in certain therapeutic categories. Navitus contracts with certain specialty pharmacy providers to distribute and manage the medications. Payers solely elect to use the specialty provider(s) and include the mandatory specialty therapies in their benefit design.

CONCURRENT DRUG UTILIZATION REVIEW

Navitus Concurrent Drug Utilization Review (C-DUR) consists of various levels of responses, depending upon the level of severity of the interaction being measured. Navitus' claims adjudication system, NaviClaim Rx, will review potential Drug-Drug Interactions, Dose Check (high/low, maximum/minimum) Drug-Sex Interactions, Drug-Age Interactions, Duplicate Therapy, and Duplicate Prescription. Potential levels of interactions are Absolute, Major, Moderate or Undetermined. Depending on the severity of the interaction, Navitus will return a DUR message. This may include passive messaging, soft rejects requiring input of outcome and intervention codes, or a hard reject requiring a call to our Customer Care center.

Hard Rejects cannot be overridden and require a call to the to the appropriate call center listed on page 5

Soft Rejects may be overridden by the pharmacy by using the following fields and values.

To override a soft reject, the following fields must be populated:

439-E4- Reason For Service Code

440-E5 - Professional Service Code and;

441-E6 - Result of Service Code

The fields are located in the DUR/PPS Segment of a NCPDP D.O transaction.

DUR/PPS Segment (please refer to NCPDP D.O payer sheet)

473-7E DUR/PPS CODE COUNTER

439-E4 REASON FOR SERVICE CODE

44Ø-E5 PROFESSIONAL SERVICE CODE

441-E6 RESULT OF SERVICE CODE

474-8E DUR/PPS LEVEL OF EFFORT

475-J9 DUR CO-AGENT ID QUALIFIER

476-H6 DUR CO-AGENT ID

Reason for Service Codes

The following codes will be accepted by Navitus:

Code	Description
AR	Adverse Drug Reaction – Code indicating an adverse reaction by a patient to a drug.
AT	Additive Toxicity – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself.
DD	Drug-Drug Interaction-Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately.
DI	Drug Incompatibility-Indicates physical and chemical incompatibilities between two or more drugs.
ER	Overuse – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted.
EX	Excessive Quantity-Code that documents the quantity is excessive for the single time period for which the drug is being prescribed.

Code	Description
HD	High Dose-Detects drug doses that fall above the standard dosing range.
ID	Ingredient Duplication- Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected.
LR	Underuse – Code indicating that a prescription refill that occurred after the days supply of the previous filling should have been exhausted.
MX	Excessive Duration- Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.
PA	Drug-Age- Indicates age-dependent drug problems.
SC	Suboptimal Compliance – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance.
SX	Drug-Gender- Indicates the therapy is inappropriate or contraindicated in either males or females.
TD	Therapeutic – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected.

Professional Service Codes

Select Professional Service Codes from the NCPDP External Code List:

Code	Description
DE	Dosing evaluation/determination – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation.
MØ	Prescriber consulted – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem.
MR	Medication review – Code indicating comprehensive review and evaluation of a patient's entire medication regimen.
PM	Patient monitoring – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered.
PØ	Patient Consulted - Patient communication related to collection of information or clarification of a specific limited problem.

Result of Service Codes

Select Result of Service Codes from the NCPDP External Code List:

1A	Filled As Is, False Positive-Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is incorrect for that prescription for that patient and fills the prescription as originally written.
1B	Filled Prescription As Is-Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and determines the alert is not relevant for that prescription for that patient and fills the prescription as originally written.
1C	Filled, With Different Dose- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dose than was originally prescribed.
1D	Filled, With Different Directions – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with different directions than were originally prescribed.
1E	Filled, With Different Drug- Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different drug than was originally prescribed.
1F	Filled, With Different Quantity – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different quantity than was originally prescribed.
1G	Filled, With Prescriber Approval – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription after consulting with or obtaining approval from the prescriber.
1K	Filled with Different Dosage Form - Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed.
2A	Prescription Not Filled - Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written.
2B	Not Filled, Directions Clarified - Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions.
3A	Recommendation Accepted – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber.

3B	Recommendation Not Accepted - Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur.
3C	Discontinued Drug - Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen.
3D	Regimen Changed - Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the recommended medication(s) after consultation with the prescriber.
3E	Therapy Changed – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber.
3G	Drug Therapy Unchanged - Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written.

For specific edits Navitus will accept:

DUR REJECT 88	REASON FOR SERVICE	PROFESSIONAL SERVICE CODE (any one of)	RESULT OF SERVICE CODE (any one of)
Drug-Drug Interactions	DD (drug to drug interaction)	DE, MØ, MR, PØ, PH	1A,1B,1C,1D,1E,1F,1G,1K,2A,2B,3A, 3B,3C, 3D,3E,3G
	AR (adverse drug reaction)	MØ, PØ, PH, MR	1A,1B,1C,1D,1E,1F,1G,1K,2A,2B,3A, 3B,3C,3D,3E,3G
	AT (additive toxicity)	DE, MØ, MR, PØ, PH	1A,1B,1C,1D,1E,1F,1G,1K,2A,2B,3A, 3B,3C,3D,3E,3G
	DI (drug incompatibility)	DE, MØ, MR, PØ, PH	1A,1B,1C,1D,1E,1F,1G,1K,2A,2B,3A, 3B,3C,3D,3E,3G

PHARMACY DRUG UTILIZATION REVIEW

Navitus requires each Participating Pharmacy to include within their pharmacy system, a system that conducts prospective drug utilization review at the time of dispensing fill. Prospective review should take place at the dispensing pharmacy's point-of-sale (POS). The prospective review at the POS should compare the prescribed medication against previous drug history for drug-to-drug, ingredient duplication, therapeutic duplication, and high dose situations. Navitus will conduct retrospective reviews that monitor prescriber and contracted pharmacies for outlier activities. Retrospective reviews should also determine whether services were delivered as prescribed and consistent with payment policies and procedures.

COMPLIANCE AND AUDITING

FRAUD, WASTE AND ABUSE (FWA)

Navitus Health Solutions, LLC does not tolerate fraudulent activity and will investigate and report any activity to the appropriate regulatory, federal and state agencies for further action and investigation. Network Pharmacies are expected to report potential misconduct, wrongdoing or potential infringements of local, state or federal laws to Navitus Compliance. Examples include:

Wholesale fraud:

- Counterfeit and adulterated drugs through black-market purchases
- Inappropriate documentation of pricing information
- Speculative buying

Pharmacy benefits management fraud:

- Prescription drug shorting
- Failure to offer negotiated prices
- Prescription drug switching

Pharmaceutical manufacture fraud:

- Illegal usage of free samples
- Kickbacks, inducements and other illegal remuneration
- Lack of integrity of data to establish payment/determine reimbursement

Pharmacy Fraud:

- Forging or altering prescriptions
- Dispensing expired prescriptions
- Refilling prescriptions erroneously
- Billing brand name drugs when generic drugs are dispensed
- Filling less or more than the prescribed quantity of a drug without authorization
- Billing multiple payers for the same prescription

Navitus Health Solutions is required to provide certification upon request to federal authorities that certain actions have been completed by vendors, contractors, associates and business entities such as:

- Training and education regarding fraud, waste and abuse upon hire/contract and annually thereafter.
- Review of the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion list for all employees, clients, pharmacies, vendors, etc. upon new hire/ contract and annually thereafter to verify that those who assist in the administration or delivery of Medicare D benefits are not included on such lists.
- Remove any person on the exclusion list from work related to all federal health care programs, take corrective actions and report findings to Navitus Compliance Department.

Navitus requires all Participating Pharmacies and their personnel including employed staff, contracted staff, and vendors to complete an annual training program that educates the staff in regards to fraud, waste, and abuse. Additionally, Navitus requires each Participating Pharmacy to complete and forward to Navitus an attestation to that effect each year.

To report Fraud, Waste and Abuse, please contact:

Navitus Health Solutions Attention: SIU
5 Innovation Court, Ste B
Appleton, WI 54914

For immediate reports, contact Navitus Special Investigations Unit (SIU) at (866)-333-2757, ext 7041 or 920-225-7041

For Medicare D reports, contact the hotline at 800-356-7344, ext.4028
    *All calls are secured and confidential.

Member Complaints

The Participating Pharmacy is required to cooperate with Navitus, Payors, and/or any state or federal entity to resolve complaints by Members. The Participating Pharmacy must make a reasonable effort in a timely manner to rectify the situation that leads to the complaint from a Member. The Participating Pharmacy must maintain written records of events and actions surrounding each complaint. The Participating Pharmacy must support all clinical programs and services, and utilize software that will display all messages related to clinical programs and services.

AUDITING

As the prescription benefit manager for various payers, Navitus has an obligation to ensure all contracted services are being provided. Compliance with the Participating Pharmacy Agreement is critical. Navitus Health Solutions Compliance will perform pharmacy audit functions to ensure program integrity.

Auditing will occur as a Desk Audit or On-site Audit. Audited pharmacies are identified based on internal analysis, external information provided to Navitus, or compliance calls to Navitus. A ten day advance notice is provided to pharmacies, unless otherwise specified in Participating Pharmacy Agreement or required by applicable State or Federal law; or suspected Fraud has been identified. In regards to suspected Fraud, no notice is required. Failure to comply may result in termination from the network.

Desk Audit: An iterative process in which the auditor and pharmacy manager exchange information via fax and/or telephone.

On-site Audit: An audit team visits the pharmacy to review the pharmacy's documentation in support of the claims submitted to Navitus.

Some claim specific audit considerations include, but are not limited to, the following errors:

- Missing signature logs, or incomplete logs
- Dispensing an incorrect drug
- Billing the wrong member
- Missing hard copy of prescription
- Using a dispense as written (DAW) code incorrectly
- Over billing quantities
- Calculating the day supply incorrectly
- Billing incorrect physician
- Using an NCPDP/NPI number inappropriately

- Dispensing unauthorized, early or excessive refills
- Pharmacy purchasing invoices that do not correspond with the NDCs of submitted claims for reimbursement
- Review of pharmacy credentials (licensures, etc.)

Should an audit take place at your pharmacy, you will receive written results. With the large volume of prescriptions processed every day, we realize human errors do occur and feel our partner pharmacies do an outstanding job of providing pharmacy services to Navitus members.

Audit Recoveries: Recoveries may be necessitated by claim errors resulting from poor documentation or filing procedures. Premature destruction, incomplete records, or missing records will not be accepted as reasons for incomplete documentation. All unsubstantiated claims are subject to recovery as a Navitus overpayment. Audit recoveries can be handled by:

- Offsetting the audit recovery amount from the pharmacy's next remittance, or
- Sending a check (payable to Navitus)

If you have any questions regarding an on-site or desk top audit contact Auditing at (920) 225-7016.

PHARMACY ADVISORY PANEL

Navitus Health Solutions has an established Pharmacy Advisory Panel as a mechanism for receiving suggestions and guidance from Participating Pharmacies about pharmacy benefit and network services. The Pharmacy Advisory Panel meets at least quarterly and includes representatives from many Navitus network distribution channels.

Navitus aspires to utilize the feedback provided through the Panel to continue its process of improving existing products and services, implementing corrective action in areas of inconsistency and strengthening our relationship with Participating Pharmacies. The interactions with the Pharmacy Advisory Panel are proactive and anticipatory with an emphasis on seeking to understand issues from the pharmacy's perspective.

Navitus focuses efforts of the Pharmacy Advisory Panel to obtain feedback in the following areas:

- Navitus Customer Care response, accuracy, and effectiveness on
- Member eligibility and benefit information.
- Formulary and claims processing issues.

- Navitus Pharmacy Network Development and Administration department accessibility, response times and effectiveness of communications mechanisms, including Navitus Pharmacy Handbook, mailings, faxes and Internet site.

- Navitus credentialing and contracting processes.

- Operational services to more effectively meet the needs of Navitus' Members, clients, and providers.

- Administrative process improvements to ensure quality service from Navitus and from pharmacies to better service our Members

To participate in the Pharmacy Advisory Panel please contact us at providerrelations@navitus.com.

CREDENTIALING/RE-CREDENTIALING/PERFORMANCE STANDARDS

Credentialing and re-credentialing initiatives exist to ensure that participating providers abide by the criteria established by Navitus health Solutions as well as governmental regulations and standards. The applicant must comply with the credentialing and re-credentialing initiatives required by Navitus Health Solutions, and agree to provide Navitus Health Solutions with documentation and other relevant information that may be required in association with such initiatives.
Navitus Health Solutions has developed a standardized process for the receipt, review, documentation and verification of applicants' credentials for participation in the Navitus Health Solutions Pharmacy Network. All applicants are subject to this review and verification process. Navitus Health Solutions has the right to determine whether an applicant meets and maintains the appropriate credentialing standards to participate as a Participating Pharmacy in the Navitus Health Solutions Pharmacy Network.

Application for Enrollment in Navitus Health Solutions Pharmacy Network
When applying for enrollment in the Navitus Health Solutions Pharmacy Network, the Contract Specialist at Navitus Health Solutions will send the applicant the Navitus Pharmacy Participation Agreement and the Pharmacy Credential Application.

The Pharmacy Participation Agreement must be signed and the credentialing applications Navitus Health Solutions credentialing standards and performance standards for pharmacy networks include, but are not limited to:

- Completion of the Participating Pharmacy Agreement including:
    - Exhibit A (Pharmacy Locations)
    - Exhibit C (Participating Pharmacy Attestation and Credentialing Application)
    - Exhibit D (Operational Assessment)
    - Section V (for Independents) and sections III, IV, V for chains (attestation signatories)

- Copies of following to be attached:
  - DEA license
  - State pharmacy license
  - Pharmacist in charge license
  - Proof of liability insurance
  - List of pharmacists employed or contracted in each pharmacy location
  - Pharmacist in charge license number
  - Signed Fraud, Waste and Abuse attestation
- Pharmacy support of all formularies published by Navitus or its Payers and to stock in its inventory all covered products listed on such formularies.
- Pharmacy compliance with the MAC list in dispensing a covered drug.
- Pharmacy maintenance of a signature log at each pharmacy location with required member signatures.
- Prescription error prevention measures and processes for handling prescription errors.
- Filling prescriptions according to the Prescriber's directions.
- Pharmacy shall not submit for reimbursement OTC products that exceed the shelf pricing.

Licensure

The prospective pharmacy must meet all standards of operation as described in Federal, State and local law and regulations. The prospective pharmacy must furnish copies of Federal, State and local licenses and/or business permits as required by applicable law when applying for enrollment as a Participating Pharmacy in the Network. Participating Pharmacy must at all times maintain in good standing all licenses and/or permits required to operate a pharmacy. Once credentialed to participate in the Navitus Network, the Participating Pharmacy must notify Navitus immediately in writing if its licenses and/or permits are canceled, revoked, suspended or otherwise terminated. Failure to immediately notify Navitus in writing of any such action may result in immediate termination from the pharmacy network. Moreover, failure to maintain the appropriate licenses and/or permits will result in immediate termination from the Navitus Pharmacy Network(s).

Insurance

When applying for enrollment as a Participating Pharmacy in the Navitus Network, the prospective pharmacy must furnish copies of policies for general and professional liability insurance, including malpractice, at a minimum in the amount of $1,000,000.00 per occurrence and $3,000,000.00 in aggregate or as otherwise required by Law. Participating Pharmacy must at all times maintain said policies in amounts necessary to ensure that the Participating Pharmacy and any of its personnel are

insured against any claims for damages arising from the provision of pharmacy services. Once credentialed to participate in the Navitus Network, the Participating Pharmacy must notify Navitus immediately in writing if its insurance is canceled, suspended or otherwise terminated. Failure to immediately notify Navitus in writing of any such termination of insurance coverage may result in immediate termination from the pharmacy network. Additionally, failure to maintain the minimum coverage will result in immediate termination as a Participating Pharmacy.

Drug Enforcement Agency Controlled Substance Registration Certificate

The prospective pharmacy must furnish a copy of Drug Enforcement Agency (DEA) Controlled Substance Registration Certificate as required by applicable law when applying for enrollment as a Participating Pharmacy in the Navitus Network. The prospective pharmacy must at all times maintain good standing with said registration. Once credentialed to participate in the Navitus Network, the Participating Pharmacy must notify Navitus immediately in writing if the DEA registration certificate is canceled, revoked, suspended or otherwise terminated. Failure to immediately notify Navitus in writing of any such action may result in immediate termination from the pharmacy network. Furthermore, failure to maintain the DEA registration certificate may result in immediate termination from the Navitus Network.

Medicaid Provider Number

When applying for participation as a Participating Pharmacy in a Medicaid or Managed Medicaid Navitus Network, the prospective pharmacy must furnish its Medicaid Provider Number as required by applicable law. The Participating Pharmacy must at all times maintain its ability to provide services to the respective states' Medicaid beneficiaries and maintain its current Medicaid Number. Once credentialed to participate in the Navitus Network, Participating Pharmacy must notify Navitus immediately in writing if its Medicaid Number is canceled, revoked, suspended or otherwise terminated. Failure to immediately notify Navitus in writing of any such action may result in immediate termination from the pharmacy network. Also, failure to maintain the Medicaid Provider Number may result in immediate termination from the Navitus Network.

Pharmacy Participation Agreement

The prospective pharmacy is required to complete, sign and return the Navitus Participation Agreement to participate in Navitus network(s). The agreement requires complete documentation including, but not limited to the Participating Pharmacy's name and address; telephone phone number; facsimile number; current state license number; current federal tax identification number; current NABP number and corporate status, as well as credentials and attestations.

Verification of Pharmacy Documentation

Upon receipt, Navitus will assemble all relevant documents and records in the Participating Pharmacy's contracting and credentialing file. Once the prospective pharmacy's credentialing file is complete, the pharmacy network credentialing coordinator will verify the prospective pharmacy's credentials by querying various databases and other sources of information to verify evidence of a current and valid permit to operate a pharmacy in the prospective pharmacy's respective State(s); current insurance policies; current and valid DEA registration; current and valid Medicaid Number; any malpractice activity; any State disciplinary actions including terminations, suspensions or reductions in privileges; any violations leading to suspension or revocation of pharmacy license or DEA registration; and any sanction activities related to Medicare, Medicaid or other governmental programs or agencies.

Navitus reserves the right to schedule meetings, including onsite meeting if applicable with the prospective pharmacy to verify information provided on the application and evaluate suspected deficiencies and/or inconsistencies in the application. Navitus wants to ensure that all pharmacies meet standards, including safety, cleanliness, patient confidentiality and access standards. The prospective pharmacy is considered to be "credentialed" and accepted into the Navitus Network when all required documentation has been verified as being valid and current, all credentialing criteria have been met, and the prospective pharmacy's credentialing status has been approved by Navitus. Moreover, the Pharmacy Participation Agreement will not be signed by an authorized Navitus designee and executed until this initial enrollment and credentialing process has been completed.

Navitus Credentialing Committee

Each month, the pharmacy network credentialing coordinator at Navitus will prepare a network credentialing report which includes information regarding the eligibility status of providers applying for enrollment and credentialing privileges in Navitus pharmacy networks. A Credentialing Committee reviews those prospective pharmacy providers that do not meet the Navitus Network criteria, contain any deficiencies identified via the credentialing process, or have issues identified with the integrity of administrative policies and procedures. The Credentialing Committee will determine the type and extent of the occurrence and make a determination in regards to participation status or the need for further review and recommendations. Final determination will be made by the Quality Oversight Committee and may include action up to and including termination from the Pharmacy Network. All such occurrences and corrective action will be placed in the Participating Pharmacy's credential file. The pharmacy network credentialing coordinator will notify the prospective pharmacy in writing of any recommendation to deny participation in the Navitus Network. The prospective pharmacy is informed in writing that he/she may appeal the decision in writing to Navitus Provider Relations within 10 business days of the receipt of the decision. All completed credentialing records will be filed in a secure area.

Re-Credentialing Standards

Participating Pharmacies are subject to re-credentialing at a minimum of every 3 years. The process for re-credentialing is identical to that of credentialing, except that as part of the review, Navitus will consider Member complaints; quality improvement review studies; utilization management review studies; pharmacy audits and customer satisfaction surveys. As with the initial credentialing verification process, the pharmacy network credentialing coordinator performs credential verifications by querying databases and other sources of information as necessary. Upon notice by the pharmacy network credentialing coordinator, Navitus requires Participating Pharmacy to return valid, updated credential documentation with the time frame specified in the notice. Participating Pharmacy is subject to termination if it fails to return updated credentials in a timely manner. Upon satisfactory completion of verifications and a preliminary assessment that Participating Pharmacy meets credentialing criteria, the pharmacy network credentialing coordinator may schedule a meeting with the pharmacy to verify information provided on the application and evaluate suspected deficiencies and/or inconsistencies in the application. Navitus wants to make certain that all pharmacies meet standards, including safety, cleanliness, patient confidentiality and access standards. Navitus retains the absolute right to conduct a facility review any time a deficiency, breaches of standards of care or delivery are suspected.

Chains with fewer than 100 locations are required to submit a spreadsheet, no more than annually with the following information:

- State license number and expiration date
- DEA number and expiration date
- Liability insurance name, policy number and expiration date
- Pharmacist-in-charge license and expiration date

Chains with more than 100 locations are required to sign an attestation that states they maintain credentials for their locations and those credentials are current and valid.

Chain/PSAOs with greater than 100 locations will be required to sign an attestation that states they are responsible for maintaining State licensure, DEA certification, liability insurance as well as any sanctions or investigations that involve their locations. Navitus will also request the following to be sent along with the signed attestation:

- Electronic copy of policy and procedures that the chain utilizes to ensure credentials are current and valid.

Navitus will perform random audits no less than annually of the chains/PSAOs credentials by requesting the electronic credentialing documentation they maintain. Navitus will verify the following during the audit:

- State licensure has been verified in the last year
- DEA certification has been verified in the last year
- Professional liability has been requested within the last year

Confidentiality and Proprietary Rights

All Member information related to Covered Pharmacy Services and other records identifying Member shall be treated by the Participating Pharmacy as confidential and proprietary. All materials relating to pricing, contracts, programs, services, business practices and procedures of Navitus are proprietary and confidential. The Participating Pharmacy must maintain the confidential nature of such materials and return them to Navitus upon termination of the agreement.

Changes in Documentation and Other Information

Participating Pharmacies must notify Navitus in writing within one business week of any changes in the documentation and other information provided to Navitus in connection with any credentialing or re-credentialing initiatives. Pharmacy updates are processed through NCPDP on a monthly basis. Please submit all changes to NCPDP immediately, in order to ensure timely processing.

Reporting of Investigations and Disciplinary Actions

Participating Pharmacy must notify Navitus immediately in writing if its license(s) and/or permit(s) have been suspended or revoked, or are in jeopardy of being suspended or revoked for any reason. The Participating Pharmacy must also notify Navitus immediately in writing if it receives notice of any proceedings that may lead to disciplinary actions, or if any disciplinary actions are taken against the Participating Pharmacy or any of its personnel, including actions by Boards of Pharmacy, the Office of Inspector General (OIG), or other regulatory bodies. Failure to immediately notify Navitus in writing of any such investigations or disciplinary actions may result in immediate termination as a Participating Pharmacy. Navitus periodically and routinely reviews federal and state exclusion databases to determine those pharmacies that are excluded from health care programs. Claims for Covered Pharmacy Services from any pharmacy that is identified as not able to participate in such programs will reject at point of sale.

Termination from Pharmacy Network

Participating Pharmacies are instructed to contact the Navitus Provider Relations immediately if they have been suspended or excluded from participating in Medicare, Medicaid or any other Federal program for any reason. Navitus will take appropriate action when occurrences of poor quality, fraud or abuse are identified, including suspending or terminating affiliation with the contracted pharmacy.

Court Orders, Subpoenas, or Governmental Requests

If Navitus receives a court order, subpoena or governmental request relating to a Participating Pharmacy, Navitus may comply with such order, subpoena or request and the Participating Pharmacy must indemnify and hold harmless Navitus for, from and against any and all costs (including reasonable attorney's fees and costs) losses, damages or other expenses Navitus may incur in connection with responding to such order, subpoena or request.

FEDERAL AND STATE CREDENTIAL AND EXCLUSION DATABASES

Navitus will periodically review Federal and State databases to monitor the regulatory actions of all Participating Pharmacies and pharmacists.

Federal databases include the Office of Inspector General (OIG) and SGA databases that identify exclusions to federal programs. If your pharmacy or personnel from your pharmacy is listed on the OIG or SGA databases, Navitus must immediately terminate our agreement. Navitus will not allow any excluded pharmacy into our network(s). Navitus will also review the DEA database to ensure that our Participating Pharmacies are able to dispense controlled substances. Navitus also routinely reviews prescribers to ensure participation in Federal programs and controlled substance writing authority

State databases include applicable state Board of Pharmacy (or similar state department) to review state license activity and disciplinary actions. If Navitus identifies a questionable license or disciplinary action, the information will be presented to the Navitus Credential Committee for further action.

MEDICARE PART D

Medicare D Navitus Pharmacy Help Desk 24/7 .... 866-270-3877 (toll-free)

www.medicarerx.navitus.com

RETRO-LOW INCOME SUBSIDY (LIS) PROCESS

According to CMS guidance that states the Prescription Drug Plans (PDP) should work with network pharmacies to provide them with direct reimbursement for any cost sharing amounts not collected from LIS-eligible enrollees. Before copayment reimbursement is made for beneficiaries that are deemed LIS-eligible and living in long-term care facilities, plans must ensure that the pharmacies in question have not collected cost-sharing amounts, otherwise waived the cost-sharing, and are in fact carrying a debt for the amounts incorrectly charged to the beneficiary.

In order for Navitus to reimburse accurately to the Pharmacy or member, Navitus requires the pharmacy to complete an attestation that directs us if the pharmacy collects copayments or not collect co pays from LIS-eligible enrollees for claims adjudicated for beneficiaries residing in long-term care facilities. Navitus uses the information provided on this attestation to determine if the member or the pharmacy is to be reimbursed for the outstanding debt.

TEXAS MANAGED CARE MEDICAID PROVIDER MANUAL

The Texas Health and Human Services Commission (HHSC) administers the Texas Managed Care Medicaid program within the State of Texas for the benefit of Texas residents.

A number of health plans in the State of Texas chose Navitus Health Solutions as their prescription benefit Management Company to administer the Texas Managed Care Medicaid pharmacy benefit on behalf of the respective Managed Care Organization. Below are unique policies and/or procedures applicable to the Texas Managed Care Medicaid program effective March 1, 2012.

Texas Provider Hotline 24/7……………………………………………………. 877-908-6023 (toll-free)

Prior Authorization ……………………………………………………….... 877-908-6023 (toll-free)

Paper claims may be sent to:
Navitus Health Solutions
Operations Division-Claims
P.O. Box 999
Appleton, WI. 54912-0999
Or fax to 920-735-5315

Claim form can be found at: www.navitus.com>members>filing a claim.

Navitus has teams of multidisciplinary individuals available to assist Participating Pharmacies with the coordination of day-to-day functions.

Navitus pharmacy help desks are available to assist you with:

- Member Plan, group and benefits information
- Member eligibility
- Formulary & Preferred Drug List (PDL) questions
- Prior authorization processes
- Claims processing issues
- Billing / payment inquiries
- Dispute and appeals process

PHARMACY PROVIDER RELATIONS DEPARTMENT

The Navitus Network Department hours of operations are Monday through Friday 8:30 a.m. – 5:00 p.m. CT. We are available to assist you with:

- Credentialing/Contracts (Pharmacy must be contracted with Texas Vendor Drug prior to obtaining contract with Navitus Health Solutions)
- Orientation
- Reimbursement / Network set-up
- MAC pricing
- General feedback regarding Navitus' performance

Contact us at: providerrelations@navitus.com or call 608-729-1577

MEDICAID FRAUD, WASTE AND ABUSE

It is everybody's responsibility to control the wastage of monies of the healthcare continuum. To that end, any reports of fraud, waste and abuse by providers, pharmacies, members or other healthcare entities should be reported and investigated to the appropriate investigative entity.

REPORTING WASTE, ABUSE OR FRAUD BY A PROVIDER OR CLIENT MEDICAID MANAGED CARE STAR AND CHIP

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 800-436-6184;

- Visit https://oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
  - MCO's name
  - MCO's office/director address
  - MCO's toll free phone number

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it.

False Claims Act (31 U.S.C. §3729-33)

The False Claims Act imposes liability on anyone who knowingly submits, or causes another to submit, a false or fraudulent claim to the United States. The term "knowingly" includes actions taken with actual intent, or one that is taken in reckless disregard or in deliberate ignorance of the truth.

This Act allows a private individual or "whistleblower" with knowledge of fraud (either in the past or the present) against the federal government, to sue on behalf of the government. This could include the recovery of civil penalties as well as triple damages. In general, the Act covers any fraud involving any federally funded contract or program with the exception of tax fraud.

The HHSC Office of Inspector General (OIG) investigates waste, abuse, and fraud in all Health and Human Services agencies in the State of Texas. To report waste, abuse or fraud please call 800-436-6184 or visit the HHSC OIG website at https://oig.hhsc.state.tx.us/.

Federal law requires all providers and other entities that receive or make annual Medicaid payments of $5 million or more to educate their employees, contractors and agents about fraud and false claims laws and the whistleblower protections available under those laws. Further details are available at www.hhsc.state.tx.us/medicaid/index.html

OR

Navitus Health Solutions Attention: SIU
5 Innovation Court, Ste B
Appleton, WI 54914

For immediate reports, contact Navitus Special Investigations Unit (SIU) at 866-333-2757, ext. 7041 or 920-225-7041

*All calls are secured and confidential.

PROVIDER COMPLAINT PROCESS TO HHSC

Medicaid Managed care pharmacies must exhaust the complaints and grievance process with Navitus Health Solutions before filing a complaint with HHSC. Pharmacy may contact the Texas Provider Hotline at 877-908-6023 to file a complaint. If after completing this process, the pharmacy believes they did not receive full due process from the respective managed care health plan, they may file a complaint or inquiry to HPM_complaints@hhsc.state.tx.us or

Texas Health and Human Services Commission
Provider Complaints
Health Plan Operations, H-320
P.O. BOX 85200
Austin, TX. 78708

For additional information visit the Texas administrative code 1 TAC 354.1003, Subchapter I.

A pharmacy may also file a complaint to the MCO (Managed Care Organization). The MCO must resolve Participating Pharmacy complaints and claims payment appeals within 30 days from the date of receipt. CHIP Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the MCO to resolve Member Complaints and Appeals (that are not elevated to TDI) within 30 days from the date the Member Complaint or Appeal is received. See below page for a list of each MCO and their website.

NAVITUS TEXAS MANAGED CARE MEDICAID PAYERS
(as of March 1, 2012)

- Texas Children's Health Plan…………………http://www.texaschildrenshealthplan.org
- Parkland Community Health Plan....................................http://www.parklandhmo.com
- Community Health Choice……………………………………https://www.chchealth.org
- Cook Children's Health Plan……………………………………www.cookchildrens.org
- Community First Health Plan……………………………………….http://www.cfhp.com
- El Paso First………………………………………………………..http://www.epfirst.com
- Driscoll Children's Health Plan…………………………………..http://www.dchpkids.com
- FirstCare Health Plan………………………………………………http://www.firstcare.com
- Sendero (Central Health)…...………………………………….http://www.senderohealth.com
- Seton Health Plan…………………………………………http://www.setonhealthplan.com

WEBSITES

Additional and timely information is available online at a number of websites.

The Navitus website is an important resource for Participating Pharmacies to refer for the most up-to-date policies and procedures, guidance, formulary and forms necessary to provide Covered Pharmacy Services to Members.

Specific Links:
www.navitus.com

The Texas Vendor Drug Program website (www.txvendordrug.com) is an important resource for Participating Pharmacies to refer for specific information in regards to the Texas Managed Medicaid and Fee-for-Service Medicaid programs.

Specific links:
Preferred Drug List (PDL) - txvendordrug.com/pdl/
Formulary - txvendordrug.com/formulary/formulary-information.shtml
Texas Medicaid - hhsc.state.tx.us/Medicaid/
HHSC - hhsc.state.tx.us
Texas Medicaid Managed Care Initiatives - hhsc.state.tx.us/medicaid/MMC.shtml
Epocrates (View Texas Vendor Drug Program Formulary and PDL) - www.epocrates.com

CLAIMS ADJUDICATION

All Participating Pharmacies must comply with NCPDP standard transactions for pharmacy drug claims, coordination of benefits and related pharmacy services. Navitus will not discriminate for the participation, reimbursement, or indemnification of any pharmacy who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. Navitus will allow pharmacies to fill prescriptions for covered drugs ordered by any licensed prescriber regardless of Network participation.

PHARMACY DEMOGRAPHIC INFORMATION

Participating pharmacies must inform NCPDP, MCO and HHSC's administrative services contractor of any changes to the Participating Pharmacy's address, telephone number, group affiliation, etc. Navitus utilizes the monthly NCPDP file so to ensure accurate payment, or any delay in electronically transmitting a claim, Participating Pharmacy must update their profile with any changes with NCPDP in a timely manner.

TIMELY FILING LIMITS

Points of Sale (POS) claims are generally submitted at the time of dispensing. However, there may be mitigating reasons that require a claim to be submitted after being dispensed. Transmission of claims using the current date for a past service date is a violation of program policy and could result in an audit exception.

The timely filing limit from the date of service is 95 days for all original claims.

Exceptions:
Claims that exceed the prescribed timely filing limit will deny with NCPDP Error 81, "Claim Too Old by x days". The exception to this is claims for Members that have been certified with retroactive Medicaid eligibility. These claims will process online for 95 days after the certification date of retroactive eligibility regardless of the date of service.

CLAIM EDITS

Following an online claim transmission by a pharmacy, the Navitus adjudicating system will return a response to indicate the outcome of processing. If the claim passes all edits, a "Paid" response will be returned with the Navitus allowed amount for the paid claim. A "Rejected" response will be returned when a claim fails one or more edits.

BASIS OF COST DETERMINATION (FIELD 423-DN)

Accepted values:

- ØØ = Default
- Ø1 = AWP (Average Wholesale Price)
- Ø3 = Direct
- Ø8 = 34ØB / Disproportionate Share Pricing/Public Health Service (for Public Health Service pharmacies only)
- Ø9 = Other (submit to indicate warehouse). Claims for drugs purchased from a Central Purchasing Entity or a Warehouse must be submitted using the value of "Ø9".

  "ØØ" will default to Direct.
  Other values will reject with code DN ("M/I Basis Of Cost Determination")

DAYS SUPPLY

The "Days' Supply" field (4Ø5-D5) is one of the key fields in Drug Use Review (DUR) edits as well as the early refill edit. Incorrect days' supply can result in inaccurate DUR alerts and can cause claims to reject for early refill. Please use the correct method of determination of days' supply (quantity divided by total dosage units per day).

The benefit limitation for quantity of Covered Products for each MCO plan may vary according to their plan limitations. Each MCO plan will cover, at minimum, 34 days' supply for those products without a specific quantity limitation. Certain MCO benefit plans for some populations may include a limited formulary that allows up to 90-day supply of Covered Products. You may attempt to process a claim for a Covered Product up to 90-days' supply using the correct days' supply field. A response that includes a NCPDP plan limitations exceeded (Reject 76) will indicate that the particular product does not qualify for 90-day supply.

Adult Medicaid Members under the Managed Care Medicaid program now are able to receive unlimited prescriptions per month. STAR MCOs in the Medicaid Rural Service Area must provide unlimited prescriptions to Members who are enrolled in a 1915(c) waiver program. STAR+PLUS MCOs will provide unlimited. CHIP Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

QUANTITY

Participating Pharmacies must submit claims for reimbursement for the amount actually dispensed at the point of sale in the "Quantity Dispensed" field (442-E7). Participating Pharmacies must dispense the quantity prescribed or ordered by the prescriber as allowed by State law or benefit design limitation put forward by the managed care plan. Many National Drug Code (NDC) numbers are packaged in a size that is not a whole number. When entering a claim for a drug that is packaged in a metric decimal sized package (i.e. 1Ø.2; 2.5; 6.8; etc.), be sure to include the decimals on your claims and do not round up. For example, if you dispense one 1Ø.2 gm inhaler, you should be entering "1Ø.2" in the "Quantity Dispensed" field. The same goes for inhalers where the package quantity is 12.9 gm for 1 inhaler. When dispensing ophthalmic drops be sure to include the decimal quantity and do not round up.

REFILLS

Refills may only be submitted when requested by the member. Participating Pharmacy must not bill Medicaid unless the Member has requested the refill – this includes pharmacies that use automated refill systems/programs.

Refill Limitations:
- DEA schedule = Ø Original + 11 refills within 365 days from original Date Rx Written
- DEA schedule= 2 No refills allowed
- DEA schedule= 3, 4, 5 Original + 5 refills within 185 days from original Date Rx Written

PARTIAL FILLS

Per HHSC requirements, no partial fill processing is allowed.

MANDATORY GENERIC REQUIREMENTS

Multi-source brand drugs will pay but will be subject to Navitus Health Solutions' Maximum Allowable Cost (MAC) Pricing.

Submit "1" in "Dispense as Written" (DAW) (Field 4Ø8-D8) to override MAC pricing when a physician wants a brand name dispensed and hand writes the phrase "Brand Necessary," "Brand Medically Necessary," "Brand Name Necessary," or "Brand Name Medically Necessary" across the face of the prescription. DAW "1" will reimburse at normal calculated cost including comparison to Usual &

Customary, and Gross Amount Due. Do note that a DAW "1" will not override the applicable MAC price for a generic product, regardless if the product is a "branded" generic.

GENERIC SUBSTITUTION

Participating Pharmacy may substitute a generically equivalent drug for the brand prescribed unless the prescriber writes in his/her own handwriting the words "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription (42 C.F.R. §447.331 and 22 T.A.C. §309.3). For electronic prescriptions, Navitus will follow the NCPDP standard designation for "Dispense as Written (i.e., DAW = 1)." The prescriber must indicate on the electronic prescription that DAW = 1 and in the "Notes to the Pharmacy," the prescriber must type "Brand Medically Necessary." If the electronic prescription is received by the pharmacy with DAW = 1 without the corresponding message, the pharmacist must contact the prescriber for a new prescription.

DME

Navitus will encourage Texas Medicaid Network Pharmacies to become Medicaid-enrolled durable medical equipment (DME) providers with the MCO's in their Service Areas.

MAIL ORDER PHARMACIES

Mail order pharmacies may be included in the network but members will not be required to utilize them. Members who do choose to utilize mail order will not be charged fees such as postage or handling for obtaining Covered Products at mail order pharmacies.

SPECIALTY PHARMACIES

Navitus may enter into selective contracts for specialty drug services, provided the arrangements comply with the HHSC Uniform Managed Care Contract access requirements, HHSC's rules, and the requirements of Texas Government Code §533.005(a)(23)(G).

If the specialty pharmacy is owned by the MCO or Navitus, Navitus must contract with at least one other specialty pharmacy and will comply with Texas HHSC definition and list of specialty drugs (when defined).

MEMBER PAYMENT INFORMATION

Copayment (CHIP only) means the amount that a member is required to pay when utilizing certain CHIP covered services. Once the copayment is made, further payment is not required by the member.

There are no prescription drug co-payments for Texas Managed Care Medicaid Members. There is a co-pay amount required for the majority of CHIP Members. The following CHIP members do not have a copayment:

- MMC members
- CHIP Perinate members
- CHIP Perinate newborn members
- Federal law prohibits charging copayments, deductibles or coinsurance to Native Americans or Alaskan Natives.

The co-pay amount due is returned in the pharmacy paid claim response, "Patient Pay Amount" (Field 5Ø5-F5).

Cost Sharing

CHIP Network Pharmacies and Out-of-Network Pharmacies may collect copayments authorized in the CHIP State Plan from CHIP Members. CHIP families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Service Contractor. The HHSC Administrative Service Contractor notifies the MCO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Contractor that a family has reached its cost-sharing limit for the term of coverage, the MCO will generate and mail to the CHIP Member a new member ID card within five calendar days, showing that the CHIP Member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

Pharmacies are responsible for collecting all Member copayments at the time of service. Copayments that families must pay vary according to their income level. Copayments do not apply, at any income level, to Covered Services that qualify as well baby, well-child care services, preventive services or pregnancy-related assistance as defined by 42 C.F.R. §457.520. Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network pharmacies and for non-covered services, the copayments outlined in the CHIP Cost Sharing Table in Uniform Managed Care Manual Chapter 6.3, "CHIP Cost Sharing", are the only amounts that an MCO may impose and a pharmacy may collect from a CHIP-eligible family. As required by 42 C.F.R §457.515, this includes, without limitation, Emergency Services that are provided at an Out-of-Network pharmacy. Cost sharing for such Emergency Services is limited to the copayment amounts set forth in the CHIP Cost Sharing Table.

Copayment amounts in the PDF listed below-
http://www.hhsc.state.tx.us/medicaid/UMCM/Chp6/6_3.pdf

PRIVATE PAY

Network Pharmacies and Out-of-Network Pharmacies are prohibited from billing or collecting any amount from a Member for Covered Services. The member's MCOs informs their Members of their responsibility to pay the costs for non-covered services, and must require the Network Pharmacy to:

1. inform Members of costs for non-covered services prior to rendering such services;

   and

2. obtain a signed private pay form from such Members.
   http://www.tmhp.com/Provider_Forms/Medicaid/Private%20Pay%20Agreement.pdf

A paper copy of the above link also included at the end of the handbook in the Appendix.

ELIGIBILITY VERIFICATION

To verify **Medicaid Managed Care STAR eligibility (CHIP eligibility is not available through TMHP EDI (TexMedConnect)**, use the following options:

- Verify electronically through TMHP EDI (TexMedConnect). Pharmacies enrolled with Texas Medicaid may inquire about a client's eligibility by electronically submitting one of the following for each client:
  - Medicaid or Children with Special Health Care Needs (CSHCN) Service Program Identification number.
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Providers can narrow the search by entering the client's county code or sex.
  - Submit electronic verifications in batches limited to 5,000 inquires per transmission.
  - Contact the TMHP Contact Center or AIS at 1-800-925-9126 or 1-512-335-5986.

Pharmacies are also encouraged to use the EVP (Eligibility Verification Portal) for eligibility verification for both STAR and CHIP.

Eligibility Verification Portal (EVP) [Web-based Tool]

The EVP is a web-based portal that is free for all pharmacies that are contracted with HHSC as Medicaid providers. This tool has been available since summer 2011.

- Pharmacies that have not already registered for EVP should download and complete the Pharmacy Enrollment Form; or call ACS Pharmacy Technical Support and Interfaces Desk at 1-888-701-1713 to request a form. Register today.
- Return the completed form either by fax (1-866-780-2185) or by e-mail (Pharmacy.MoveIT@tmhp.com).
- Enter client Social Security Number of client does not present their enrollment card, to get Medicaid/CHIP ID number
- Enter Medicaid/CHIP ID number to get eligibility and MCO enrollment information.
- Questions about access should be directed to the ACS-Pharmacy Technical Support and Interfaces Desk at 1-888-701-1713.

Beginning March 1, 2012, the EVP response will identify the client's managed care plan, in addition to verifying the client's eligibility for Medicaid or CHIP.

Automated Toll-Free Voice Response System (AVRES)

Beginning March 1, 2012, pharmacists will have a new tool, the ***Your Texas Benefits Card*** Medicaid Eligibility service for pharmacists.

- 1-800-668-0650
- Enter Medicaid ID number to verify eligibility and MCO enrollment.

Mother's eligibility

For mothers who currently receive CHIP perinatal and have an income at or below 185 percent of the FPL, and who receive Emergency Medicaid coverage, Participating Pharmacies can check eligibility by performing eligibility verification on the TMHP website at www.tmhp.com or calling the TMHP AIS at 1-800-925-9126.
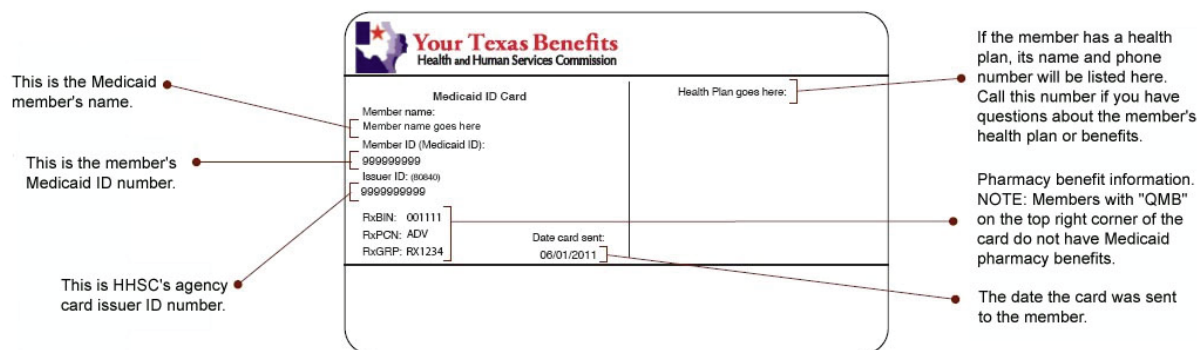
Newborn's eligibility

For CHIP Perinatal newborns with a family income at or below 185 percent of the Federal Poverty Level, Participating Pharmacies can obtain eligibility information and the newborn's PCN by performing eligibility verification on the TMHP website or by calling TMHP Contact Center at 1-800-925-9126. CHIP Perinatal Program newborn PCN information is not available through AIS.

To process a claim for a newborn please utilize the temporary proxy ID that the MCO assigns until the newborn receives their own unique member ID, The algorithm to create a temporary identification number for newborns will be the mothers ID plus two additional characters (i.e. NB or 01). The temporary ID number will be allowed until such time as the newborn receives their own permanent identification number within a few days or weeks.

YOUR TEXAS BENEFITS MEDICAID MEMBER ID CARD

HHSC has recently introduced the Your Texas Benefits Medicaid card. This will replace the Medicaid ID letter (Form 3087) members have been getting in the mail every month. The card will show:

- Member name and Medicaid ID number
- Billing information for pharmacies (BIN/PCN, RX Group and Customer Care Hotline)

Back of ID card
- Will have a statewide toll-free number that members can call if they need help or have questions about using the card.
- A website (www.YourTexasBenefits.com) where members can get more information about the Medicaid card and access their personal Medicaid health history. The website will be fully functional in a later phase of the project.

Members will also be provided a medical ID card from their Managed Care Organization (MCO). You may contact the number on the back of this card for questions or to verify eligibility. Member ID cards will vary depending on MCO.

FORMULARY AND PRIOR AUTHORIZATION

General Policies

Texas Managed Care Medicaid payers must adopt prior authorization policies and procedures for non-preferred drugs, which are drugs that are not on the HHSC's Preferred Drug List (PDL). The policies must comply with state and federal laws, including 42 U.S.C. §1369r.

Payers must adhere to the Formulary and PDL for Medicaid. Preferred drugs must adjudicate as payable without prior authorization, unless they are subject to clinical or administrative edits. HHSC approval is required for any clinical edit policies.

Payers must adopt prior authorization policies unless HHSC grants a written exception. HHSC's Medicaid prior authorization policies, and Medicaid PDL, are available on HHSC's website. HHSC's website includes exception criteria for each drug class included on HHSC's Medicaid PDL. Payers may require that the prescriber's office request prior authorization as a condition of coverage or payment for a prescription drug provided that: 1) A decision to approve or deny the prescription is made within 24 hours of the prior authorization request, and 2) If a Member's prescription for a medication is not filled with a prescription is presented to the pharmacist due to a prior authorization, Navitus on behalf of the payer, or the payer, must instruct the pharmacist to dispense a 72 hour emergency supply of the prescribed medication if the prescriber cannot be reached. The pharmacy may fill consecutive 72 hour supplies if the prescriber remains unavailable. Navitus will reimburse the pharmacy for dispensing the temporary supply of medication. The requirement that the Member be given at least a 72-hour supply for a new medication does not apply when the dispensing pharmacist determines that the taking of the prescribed medication would jeopardize the health or safety of the Member. In such event, payers will require that the Participating Pharmacy make a good faith effort to contact the prescriber.

PREFERRED DRUG LIST

Texas Medicaid maintains a Preferred Drug List (PDL) comprised of various therapeutic classes. Prescriptions written for preferred drugs will be available without prior authorization, while non-preferred drugs will require prior authorization. Prescribers will need to contact Navitus to obtain approval before the drug can be dispensed. A 72-hour emergency supply should be dispensed any

time a prior authorization is not available and a prescription must be filled for any medication or medical condition (see below).

CLINICAL PRIOR AUTHORIZATION EDITS

Clinical Prior Authorization edits check a Member's Medicaid medical and drug claims histories to help determine whether the information on file indicates that the patient's medical condition matches the edit criteria for dispensing the requested drug without need of additional prior authorization. The edits are based on evidence based clinical criteria and nationally recognized peer reviewed information and are reviewed by the Navitus P&T committee. A 72-hour emergency supply should be dispensed any time a clinical edit prior authorization is not available and a prescription must be filled for any medication or medical condition (see below). If you receive a rejection message of "*75- Prior Authorization Required,*" the physician can request a Prior Authorization form to be faxed to them or you can download the form from www.navitus.com.

72-HOUR OVERRIDE EMERGENCY PRESCRIPTION SUPPLY

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour emergency supply.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

A Pharmacist should use his/her professional judgment regarding whether or not there is an immediate need every time the 72-hour option is used. This procedure should not be used for routine and continuous overrides. A 72-hour emergency prescription will be paid in full.

To be reimbursed for a 72-hr emergency prescription supply, Participating Pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU).

- "8Ø1" in "Prior Authorization Number Submitted" (Field 462-EV).
- "3" in "Days' Supply" (Field 4Ø5-D5, in the Claim segment of the billing transaction)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g. an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispense.

72-hour Emergency Prescription Rejection Message (Required Language)
The following message will be returned to pharmacies on all electronically-submitted claims that the MCO rejects because the prior authorization criteria have not been met:

"Prescriber should call [insert hotline or call center name and number] or pharmacist should submit 72 hour Emergency Rx if prescriber not available."

Call the Navitus Contact Center for more information about the 72-hour emergency prescription supply policy.

PRIOR AUTHORIZATION

Navitus processes Texas Medicaid pharmacy prior authorizations for each contracted MCO eligible members. The formulary, prior authorization criteria, and the length of the prior authorization approval are determined by HHSC. Information regarding the formulary and the specific prior authorization criteria can be found at the Vendor Drug Website, Epocrates, and SureScripts for ePrescribing.

Prescribers can access prior authorization forms online via www.navitus.com under the "Prescribers" section or have them faxed by our Texas Provider Hotline staff to the prescriber's office. Prescribers will need their NPI Number and State to access the portal. Completed forms can be faxed 24/7 to Navitus at 920-735-5312. Prescribers can also call the Navitus Texas Provider Hotline at 877-908-6023 > prescriber option and speak with the Prior Authorization department between 8a-5p M-F Central Time to submit a PA request over the phone. After hours, providers will have the option to leave voicemail. Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will undergo an automated review to determine if the criteria are met for approval. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the

pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the above mentioned process should be followed.

When a Prior Authorization is required and the provider is not available to submit the PA request, HHSC requires pharmacies to dispense a 72 hour emergency supply as long as the member will not be harmed if the PA is denied and therapy will be discontinued. The 72 hour emergency supply is for any Medicaid STAR recipient if the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription. This also applies if a PA request was submitted but Navitus could not make a decision within 24 hours of receipt. This procedure should not be used for routine and continuous overrides but can be used more than once if the provider remains unavailable. If a pharmacy is not complying with the 72-hour emergency supply requirement, they can be reported to the HHSC Office of Inspector General and Navitus' Network's department at 608-729-1577 for review.

INSULIN AND SYRINGES

Covered Products for diabetics has been expanded under the Texas Managed Care Medicaid program. The following items are Covered Products:

- Insulin
- Insulin Syringes

DIABETIC TEST STRIPS DRUG COVERAGE

Separate formularies are maintained for each program (Medicaid STAR and CHIP,). Further information regarding coverage is available online at each managed care organization / health plans respective website. In addition, the following websites will contain the HHSC approved formularies:

Epocrates (View Texas Vendor Drug Program Formulary and PDL) - www.epocrates.com Preferred Drug List (PDL) - txvendordrug.com/pdl/
Formulary - txvendordrug.com/formulary/formulary-information.shtml

For consideration to have non-formulary products added to the HHSC approved formulary, please contact HHSC Vendor Drug.

Excluded:

- DESI drugs are not covered.
- Durable Medical Equipment (DME), such as crutches, wheel chairs, etc. is not covered under the pharmacy program. Exception to this is certain durable medical supplies for

diabetes, such as insulin syringes, test strips, etc. Each managed care organization will enter into agreements with accredited DME pharmacy suppliers directly for reimbursement of DME products.

DISPENSING LIMITATIONS

- Anorexics Weight management diagnoses will be denied. Prior Approval required for age 21 years and over.
- Anti-Fungal Anti-Fungal limitation is 18Ø day supply per calendar year.
- Biosynthetic Growth Hormone Prior Approval and documentation of appropriate diagnosis required.
- Enzymes Vendor Drug reimburses the following products: Tyvaso Kit, Sucraid, Naglazyme, Fabrazyne, Ceprotin, Cerezyme, Adagen, Myozyme, Elaprase, and Aldurazyme.
- Erectile Dysfunction drugs Erectile Dysfunction drugs are not covered.
- Family Planning Family planning drugs prescribed for contraception are not covered by CHIP.
- Migraine medications limitations are across strengths per calendar month for each drug.
- Pediculosis treatment Doctors can write one prescription for the whole family if a child is diagnosed with lice or scabies.
- Prenatal Vitamins Prenatal Vitamins Limitation is for females under the age of 5Ø only.
- Stadol limitation is 1Ø ml per calendar month (4 bottles).
- Xenical Obesity management diagnoses will be denied. Prior Approval and documentation of hyperlipidemia required.

Appropriate prior authorization forms, when required, are available at www.navitus.com.

PHARMACY REIMBURSEMENT

Navitus will pay clean claims submitted electronically no later than 18 days after adjudication and paper claims will be paid within 21 days of being adjudicated.

Navitus reimbursement payment cycle for Texas Medicaid will be weekly. Navitus offers Participating Pharmacies the option of receiving payments via ACH vs. paper if they so choose. In order for Participating Pharmacies to receive ACH payments they must complete the Electronic Fund Transfer

(EFT) form. The may request this form by contacting the Pharmacy Network team at (608) 729-1577 or via email at providerrelations@navitus.com. Once the form is completed and sent back to Navitus please allow 14-21 business days to setup.

REMITTANCE ADVICES

Navitus offers electronic ASC X12 5010 835 remittances as well as paper remittances.

- Electronic remittances may be accessed through our secured FTP server.
- If you are interested in receiving electronic remits, complete the 835 Request Form (see Addendum or www.navitus.com > Pharmacies > Pharmacies Login).
- Fax the completed form to Navitus using the number on the form.
- Allow 21 business days for setup. Navitus does place test files on the FTP server to assure a smooth transition for your pharmacy(s).
- Navitus reserves the right to charge an additional fee to recreate an 835 file or create a CD.
- Claims denied through the online adjudication system do not appear on the Remittance Advice.
- All payees requesting electronic fund transfer (ACH) for Medicaid reimbursement will be required to accept electronic 835 remittances.

THIRD PARTY BILLING

When a Texas Medicaid Member has coverage for prescription drugs through another third party payer, the Participating Pharmacy must bill all other third party payers and insurance before billing Medicaid. If other insurance exists in the Members Third Party Liability file as provided by the State to the MCO and Medicaid is billed as the primary insurer, then the claim will reject at point of sale with error code 41 ("Submit Bill To Other Processor or Primary Payer"). Additional information will be returned via the POS to the Participating Pharmacy with the third-party billing information needed for claims submission to the other payer. The message will be returned in "Additional Message Information" (Field 526-FQ) and read "Bill Other Payer (Payer ID:x, Policy No:x, BIN:x, PCN:x, Group:x, Cardholder ID:x)".

If the pharmacy submits the claim to the primary payer and it is denied, the pharmacy should contact the primary payer to address the denial reason. If the claim is not payable by the other insurer, Medicaid may pay the claim depending on the reason for denial (including expired coverage). Participating Pharmacy should submit the claim and include the other payer's rejection code in the

"Other Payer Reject Code" field (472-6E). Claims must be submitted within 95 days of the disposition of the other insurer to meet timely filing requirements.

If the Member is assessed a deductible or co-payment, the Participating Pharmacy should submit the claim to Medicaid (as secondary payer) and include the amount paid by the primary insurer. Navitus will pay deductibles and co-payments, up to the amount that Navitus would have reimbursed per the reimbursement in the Agreement for eligible Members and Covered Products.

FREQUENTLY ASKED QUESTIONS

How can a Pharmacy join the Network?

Contact the Pharmacy Network Department for information.

providerrelations@navitus.com or call 608-729-1577.

Once the Contract request is faxed, how long until it is mailed out?

Allow 2-3 business days for contract to be sent. If you would like the contract(s) faxed please let us know at the time of the request.

When the Contract is mailed back, how long until we can process claims?

Allow 5-7 business days for an independent contract and 7-10 business days for a chain/PSAO contract.

How can I change my address and/or Tax ID number?

Update pharmacy information with NCPDP. We receive a monthly file from NCPDP. Submit your update to NCPDP by the 15th of the month in order for it to be on the next monthly file load.

What do I do if a customer states the amount charged for their prescription is incorrect?

You may contact the appropriate call center listed on page 5 for verification of the patient pay amount.

What is the Member ID number and format?

Refer to Member ID for exact format

What BIN number do I enter?

BIN 610602

Does Navitus Health Solutions provide a Web site for pharmacies?

Yes, it is www.navitus.com > Pharmacies > Pharmacies Login. You can obtain payer sheets, news bulletins, updates/alerts and much more!

Who do I contact for payment/remit questions?

Contact the Navitus Pharmacy Help Desk at 866-333-2757 and the call/issue will be routed to the appropriate department.

Who do I contact if I want to file a dispute or appeal?

Contact the Pharmacy Network Department at 608-729-1577 or via email at
providerrelations@navitus.com

How can I file a complaint about Navitus?

A verbal complaint may be filed by contacting the appropriate Navitus Pharmacy Help Desk. A written complaint may be submitted to the attention of the Pharmacy Network Department at 5 Innovation Court, Suite B, Appleton, Wisconsin 54914.

What are some of the common reject codes and the process to follow if received?

Contact the Navitus Pharmacy help desk at (866) 333-2757 if you receive the following:

Missing/Invalid cardholder ID-reject 07

Missing/Invalid Date of Birth-reject 09

Missing/Invalid Group Number-reject 06

Invalid Day Supply-reject 19

Refill to Soon- reject code 79

Invalid NDC (National Drug Code)-reject 21

DUR- Reject 88

DEFINITIONS

Average Wholesale Price or "AWP" means the average wholesale price for a given pharmaceutical product, as published by Medi-Span or another national drug database reporting service used by Navitus.

Coordination of Benefits and Subrogation (COB). Participating Pharmacy agrees to cooperate with Navitus in the effective implementation of COB and subrogation programs, including, but not limited to, online adjudication for COB claims.

Compound Prescriptions means a mixture of two or more ingredients with at least one ingredient that utilizes a Prescription Drug that is a Covered Product. A prescription will not be considered a Compound Prescription if it is reconstituted or if, to the active ingredient, only water, alcohol or sodium chloride solutions are added.

Copayment, Coinsurance or Deductible means the amount of money a Member is required to pay Participating Pharmacy for Covered Products in accordance with that Member's Plan Specifications and the terms of this Agreement.

Covered Pharmacy Services means, with respect to Participating Pharmacy, the dispensing of Covered Products and the provision of other related services, which a Member is entitled to receive, and for which the appropriate Payor is obligated to pay, pursuant to applicable Plan Specifications and this Agreement.

Day(s) Supply means the number of days that the dispensed quantity of a Covered Product is expected to last. The Days Supply shall be calculated as the quantity dispensed divided by the number of units used each day as directed by the prescribing Practitioner's direction for use, subject to each Payor's Plan Specifications. Participating Pharmacy, for purposes of calculation of Copayment, Coinsurance or Deductible must submit via Online Adjudication Processing the accurate number of Days Supply of a Covered Product dispensed to Member.

Force Majeure. A party shall not be deemed to have breached this Agreement if its delay or failure to perform all or any part of its obligations hereunder results from a condition beyond its reasonable control, including without limitation, acts of God or the public enemy, flood or storm, strikes, riots, terrorist acts, war or other outbreak of hostilities, natural disaster, power or communication line failure, statute, or rule or action of any federal, state or local government agency.

Formulary means a list of preferred Prescription Drugs developed, published and periodically revised by Navitus' pharmacy and therapeutics committee or a Payor, which Practitioners are encouraged to prescribe and Participating Pharmacies are required to dispense, consistent with their professional judgment and applicable Law, and which Members are encouraged to use.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

HIPAA Privacy Rule means the federal rules and regulations related to the use and disclosure of patients' Protected Health Information under 45 CFR Parts 160 and 164.

HIPAA Rules mean the medical records privacy, security and standard transaction rules and regulations under 45 CFR Parts 160, 162 and 164.

Law means any federal, state or local law, ordinance, rule, regulation or judicial or administrative interpretation thereof.

Maximum Allowable Cost or "MAC" means the compensation level established and modified by Navitus in its discretion from time to time, for multiple source drugs.

Members means individuals covered under a Payor's plan.

NCPDP means the National Council for Prescription Drug Programs or its successor.

Network Pharmacy(ies) means the pharmacies that have entered into Participating Pharmacy Agreements with Navitus to provide Covered Pharmacy Services to Members.

NPI means the National Provider Identifier provided by the Centers for Medicare and Medicaid Services through the National Plan & Provider Enumeration System (NPPES), or its successor, as published by NCPDP or another NPI reporting service used by Navitus.

Online Adjudication Processing means the transmission of Prescription Drug claims from Participating Pharmacy to Navitus in compliance with the transaction standards set forth in applicable Law including the HIPAA Rules and, in turn, Participating Pharmacy receiving, via online messaging, information including, but not limited to, eligibility and coverage determination, and applicable Deductibles, Coinsurance and Copayments.

Plan Specifications means the coverages, exclusions and limitations of Covered Products under a Payor's health benefit plan, as may be identified through an online identification of Covered Products; excluded items; applicable Coinsurance, Copayment and Deductible amounts; benefit maximums; and other items in connection with a particular plan specifications required by a Payor.

Practitioner means a physician or other health provider licensed in the state where the prescription is issued and who is authorized by Law to prescribe medication, devices and/or supplies to individuals including Members.

Payor means an employer, government or governmental authority, health maintenance organization, insurance company, managed care organization, preferred provider organization, self-funded plan or group, third party administrator or other entity responsible for providing access to a prescription drug program or funding payments of Covered Pharmacy Services under its Plan Specifications or in connection with the coordination of benefits and has selected one or more of Navitus' networks.

Protected Health Information or "PHI" means individually identifiable health information related to the past, present, or future physical or mental health or condition of a Member; the provision of health care to a Member; or the past, present or future payment for the provision of health care to a Member, as more fully defined in the HIPAA Privacy Rule or otherwise deemed confidential under federal or state Law.

Usual and Customary Price means the retail price charged by a Participating Pharmacy location for a particular Prescription Drug in a cash or uninsured transaction, on the date such Prescription Drug is dispensed by such Participating Pharmacy location.

Wholesale Acquisition Cost or "WAC". Means the wholesale acquisition cost for a given pharmaceutical product, as published by Medi-Span or another national drug database reporting service subscribed to by Navitus, updated weekly in Navitus' claims processing system and used by Navitus for the purpose of determining the Calculated Prices of certain Prescription Drugs that are Covered Products.

APPENDIX

Navitus Pricing Research Request Form

Fax completed form and provide other required elements to: (920) 735-5351
Expected response time: 5 business days from date received

Pharmacy Name:		Date Requested:
NCPDP#:	Email Address:	
Contact Name:	Phone #:	Fax #:

Claim Information: Complete the section below or attach copy of claim transaction.

Rx #:	Fill Date: / /	Amt Submitted:	Disp. Fee:	Total Paid:
Drug Name & Strength:			NDC #: _ _ _ _ _ - _ _ _ _ -_ _	
Qty Dispensed:		Days' Supply	U & C Price:	

Other Requirements:
Invoice or Proof of Acquisition Cost must accompany this request.

Comments:
_____
_____
_____

Followed up with Pharmacy on: _____

The information contained in this FAX transmission is intended solely for the individual named above and may contain confidential and/or privileged information. Therefore, this FAX must be secured and protected in accordance with state and federal laws regarding the treatment of confidential information, medical privacy or other requirements (legal or business practice). If you, the reader of this FAX cover sheet, are not the individual named above or an authorized representative of the individual named above, you are hereby notified that any review, dissemination, use, copying or retention of this FAX or any part of the information herein is strictly prohibited.

If you have received this FAX in error, please notify the sender immediately by phone and destroy this FAX.

CONFIDENTIAL
2601 West Beltline Highway, Suite 600
Madison, WI 53713

To be completed by Payer:

1.   Federal Tax ID (Required for EFT): 04-3608530
2.   Additional Tax ID information (optional):
3.   **I**nclude or **E**xclude Rejected Claims: **Exclude**
4.   **I**nclude or **E**xclude Non Payment Claims: **Include**
5.   Communication
   a.   E-mail Address: navitusnetworkingteam@navitus.com
   b.   Telephone Number: 608-729-1577
   c.   Facsimile Phone Number: 920-735-5351

To be completed by Payee:

1.   **Payee Name and address:**

2.   **Payee Contact**
   a.   Contact Name:
   b.   Fax:
   c.   E-mail:

3.   **Affiliation number or NABP number(s):**

4.   **Payee Tax ID:**

5.   **Technical/EDI Contact – This will be the person that is going to be pulling your 835 remits from our ftp server.**
   a.   Contact name:
   b.   Phone:
   c.   Fax:
   d.   E-mail Address:

6.   **Sender/Receiver ID:**

7. **Sender/Receiver ID Qualifier:**
  a.   01 - Duns Number
  b.   12 - Phone Number
  c.   ZZ - Mutually Defined (commonly used, can be anything from a company name to an internal system number)

8. Method of Communication: FTP Pull

Navitus will only support FTP Pull at this time.

9.   Does your pharmacy utilize a Centralized Payment Method?
If yes, provide check and remit address:

10.   Does your pharmacy utilize a Reconciliation Company?
If yes, provide Reconciliation Company Name:

Contact name:

Fax:

E-mail:

Please be sure to send any updates that will affect your electronic remits or payments to Navitus Health Solutions in a timely manner. Failure to do this may result in incorrect payment or payment address. Navitus Health Solutions will rely on the information contained herein to process and deliver Pharmacy's remittance advice and Pharmacy payments.

To be completed by Navitus Health Solutions:

Contract Analyst:

Pharmacy Name:

Payee ID (Chain Code):

Date Completed Request Worksheet Received:

Part 1: Member Information

1. *Complete ALL information. Your ID Number can be located on your member ID card.*

2. *Submit claims within the filing period specified by your Benefit plan. For questions about your filing period please review your Member handbook or call the Customer Care number on your member ID card.*

3. *Please submit a separate form for each patient for which you purchased medications.*

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information

1. *Complete ALL information.*

2. *Please submit a separate form for each pharmacy from which you purchased medications.*

Name		
Street Address		
City	State	ZIP Code
Pharmacy National Provider Number		Telephone Number ( )
Pharmacist Signature		

For Reimbursement of Compound Drug Preparation, see the table below.
Please indicate the time spent preparing the compound drug in the Receipt Information on page 2.

Time	Reimbursement
1 – 5 minutes	$10.00
6 – 15 minutes	$15.00
16 – 30 minutes	$20.00
31+ minutes	$25.00

65

Part 3: Receipt Information

1. *Include original pharmacy receipt(s) or pharmacy printout(s); Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape original pharmacy receipt(s) to additional page and submit with claim form.* Please *DO NOT staple.*

   a. *Compound medications must have at least 2 ingredients, and at least 1 ingredient must be a Federal legend drug.*

   b. *All active ingredients must be covered as part of your formulary and all script information must be submitted.*

2. *Receipt(s) must contain the information outlined under Part 3. If your receipt(s) are missing any of this information, please have your pharmacist fill in the missing information.*

3. *Please provide the explanation of benefits (EOB) or denial letter from the primary insurance carrier if you have primary coverage with another insurance carrier.*

4. *An incomplete form may be denied, delayed or returned.*

5. *Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.*

Date Rx Filled	Diagnosis Code and Description	
Rx Number	Final Form of Compound (cream, patches, suppository, suspension, etc.)	
Diagnosis Code/Description	Total Volume (grams, ml, each, etc.)	Day Supply
Prescribing Physician First/Last Name		Prescribing Physician NPI
Original Cost of Rx	Amount Primary Insurance Paid on Rx	Member Paid Amount

Compound Ingredients

	Ingredient Name	Ingredient NDC	Metric Decimal Quantity	AWP/WAC
1				
2				
3				
4				
			Total Ingredient	

Cost	
Preparation Time	
Member Copay	

Reimburse	
(Circle One)	
Pharmacy	Member

Mail this form along with receipts to:

Navitus Health Solutions, LLC
P.O. Box 999

Appleton, WI 54912-0999

OR

Fax this form along with receipt(s) to:

(920)735-5315

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ *Patient Training on Glucose Monitors:*
Reimbursement: $1.00/minute up to 30 minutes ———
NDC: 99999-999-36

☐ *Patient Training on Asthma Inhaler/Peak Flow Meter*
Reimbursement: $1.00/minute up to 10 minutes ———
NDC: 99999-9999-37

☐ *Patient Training on Blood Pressure Monitors*
Reimbursement: $1.00/minute up to 15 minutes ———
NDC: 99999-9999-38

☐ *Patient Training on Nasal Inhalers*
Reimbursement: $1.00/minute up to 5 minutes ———
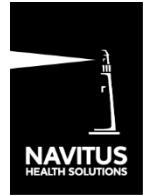NDC: 99999-9999-39

Rx Number from original prescription: ————

Patient Signature: ————————

Prescriber's Name: ————————

Date of Intervention: ————————

Patient Training

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ *Patient Training on Glucose Monitors:*
Reimbursement: $1.00/minute up to 30 minutes ———
NDC: 99999-999-36

☐ *Patient Training on Asthma Inhaler/Peak Flow Meter*
Reimbursement: $1.00/minute up to 10 minutes ———
NDC: 99999-9999-37

☐ *Patient Training on Blood Pressure Monitors*
Reimbursement: $1.00/minute up to 15 minutes ———
NDC: 99999-9999-38

☐ *Patient Training on Nasal Inhalers*
Reimbursement: $1.00/minute up to 5 minutes ———
NDC: 99999-9999-39

Rx Number from original prescription: ————

Patient Signature: ————————

Prescriber's Name: ————————

Date of Intervention: ————————

Patient Training

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ *Patient Training on Glucose Monitors:*
Reimbursement: $1.00/minute up to 30 minutes ———
NDC: 99999-999-36

☐ *Patient Training on Asthma Inhaler/Peak Flow Meter*
Reimbursement: $1.00/minute up to 10 minutes ———
NDC: 99999-9999-37

☐ *Patient Training on Blood Pressure Monitors*
Reimbursement: $1.00/minute up to 15 minutes ———
NDC: 99999-9999-38

☐ *Patient Training on Nasal Inhalers*
Reimbursement: $1.00/minute up to 5 minutes ———
NDC: 99999-9999-39

Rx Number from original prescription: ————

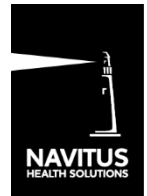Patient Signature: ————————

Prescriber's Name: ————————

Date of Intervention: ————————

Patient Training

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ *Patient Training on Glucose Monitors:*
Reimbursement: $1.00/minute up to 30 minutes ———
NDC: 99999-999-36

☐ *Patient Training on Asthma Inhaler/Peak Flow Meter*
Reimbursement: $1.00/minute up to 10 minutes ———
NDC: 99999-9999-37

☐ *Patient Training on Blood Pressure Monitors*
Reimbursement: $1.00/minute up to 15 minutes ———
NDC: 99999-9999-38

☐ *Patient Training on Nasal Inhalers*
Reimbursement: $1.00/minute up to 5 minutes ———
NDC: 99999-9999-39

Rx Number from original prescription: ————

Patient Signature: ————————

Prescriber's Name: ————————

Date of Intervention: ————————

Patient Training

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ Formulary Interchange Reimbursement: $4.00
NDC: 99999-999-32

☐ Therapeutic Interchange Reimbursement: $12.00
NDC: 99999-9999-33

☐ Change of Dose Reimbursement: $5.00
NDC: 99999-9999-38

Rx Number from original prescription: _____

Patient Signature: _____

Prescriber's Name: _____

Date of Intervention: _____

☐ Patient Compliance Monitoring Reimbursement: $10.00
NDC: 99999-9999-35

Rx Number from original prescription: _____

Patient Name: _____

Date of Intervention: _____

Outcome: _____

Clinical Services

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ Formulary Interchange Reimbursement: $4.00
NDC: 99999-999-32

☐ Therapeutic Interchange Reimbursement: $12.00
NDC: 99999-9999-33

☐ Change of Dose Reimbursement: $5.00
NDC: 99999-9999-38

Rx Number from original prescription: _____

Patient Signature: _____

Prescriber's Name: _____

Date of Intervention: _____

☐ Patient Compliance Monitoring Reimbursement: $10.00
NDC: 99999-9999-35

Rx Number from original prescription: _____

Patient Name: _____

Date of Intervention: _____

Outcome: _____

Clinical Services

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ Formulary Interchange Reimbursement: $4.00
NDC: 99999-999-32

☐ Therapeutic Interchange Reimbursement: $12.00
NDC: 99999-9999-33

☐ Change of Dose Reimbursement: $5.00
NDC: 99999-9999-38

Rx Number from original prescription: _____

Patient Signature: _____

Prescriber's Name: _____

Date of Intervention: _____

☐ Patient Compliance Monitoring Reimbursement: $10.00
NDC: 99999-9999-35

Rx Number from original prescription: _____

Patient Name: _____

Date of Intervention: _____

Outcome: _____

Clinical Services

**Pharmacy Care Incentives
On-Line Adjudication
Documentation**

☐ Formulary Interchange Reimbursement: $4.00
NDC: 99999-999-32

☐ Therapeutic Interchange Reimbursement: $12.00
NDC: 99999-9999-33

☐ Change of Dose Reimbursement: $5.00
NDC: 99999-9999-38

Rx Number from original prescription: _____

Patient Signature: _____

Prescriber's Name: _____

Date of Intervention: _____

☐ Patient Compliance Monitoring Reimbursement: $10.00
NDC: 99999-9999-35

Rx Number from original prescription: _____

Patient Name: _____

Date of Intervention: _____

Outcome: _____

Clinical Services

Texas Medicaid Private Pay Agreement

I understand _____ is accepting me as a private pay

                                 (Provider Name)

patient for the period of _____, and I will be responsible for paying

for any services I receive. The provider will not file a claim to Medicaid for services

provided to me.

Signed: _____

Date: _____