



Passport Advantage



Pharmacy Services Provider Manual

2009



**PHARMACY PROVIDER MANUAL
PASSPORT ADVANTAGE
JANUARY 2009**

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FOREWORD

This Pharmacy Provider Manual is an administrative program guide to assist network pharmacy providers with understanding Passport Advantage pharmacy benefits and how they are administered by PerformRx Pharmacy Services.

If you have questions, comments, or suggestions, please call PerformRx Help Desk at (866) 533-5490 or write to:

PerformRx
200 Stevens Drive, 4th Floor
Philadelphia, PA 19113
Attn: PerformRx Pharmacy Services

INTRODUCTION

PerformRx

PerformRx provides "The Next Generation" of pharmacy benefit management services through a distinctive approach for managed care plans and payers nationwide, with unique expertise in Medicaid and Medicare Part D. PerformRx is headquartered in Philadelphia, Pennsylvania.

PerformRx is a mission-driven organization, dedicated to the delivery of quality pharmacy benefits to low-income populations covered by publicly funded programs. This commitment directly reflects the vision of our parent company, AmeriHealth Mercy.

AmeriHealth Mercy Family of Companies

The AmeriHealth Mercy Family of Companies is the largest organization of Medicaid managed care Plans in the United States, touching the lives of more than 6.2 million members. With more than 20 years of experience exclusively serving the Medicaid population, AmeriHealth Mercy's core products include management, administrative, pharmacy benefit, care management services and behavioral health care services.

Passport Advantage

Passport Advantage (PAD) is a Medicare Advantage Prescription Drug Special Needs Plan (MAPD-SNP) covering all Medicare benefits—Parts A, B, and D—for a certain group of Medicare beneficiaries. **Individuals must be current Passport Health Plan members with Medicare Parts A and B to join.** PAD offers low copayments and \$0 coverage gaps for our members' covered prescriptions.

The prescription drug benefit is administered through PerformRx, the Plan's Pharmacy Benefits Manager. PerformRx is also responsible for additional services to the Plan, such as credentialing, processing all pharmacy claims, handling receipts and approval of all prior authorizations, auditing pharmacies, and working with the Plan's Pharmacy and Therapeutics Committee to communicate routine and urgent issues.

PERFORMRX HELP DESK

Pharmacies are contractually obligated to call the PerformRx Help Desk to ensure prompt resolution to pharmacy claims issues, including claim rejections for prior authorization.

The PerformRx Pharmacy HelpDesk will be able to resolve online, concurrent DUR claim processing issues, including but not limited to:

- Pharmacy coding errors;
- Prior authorization (PA)/Coverage Determination;
- Coordination of Benefits (COB)/Third Party Liability (TPL);
- Duplicate therapy
- Early refills and frequency limitation;
- Duplicate drugs;
- Potential drug interaction(s);
- Drug preference messaging; and
- Minimum/maximum dose range.

The Pharmacy HelpDesk will also provide support and answer questions about:

- The PAD Formulary;
- Coverage Determination Status;
- Coordination of Benefits;
- Quantity Limits;
- Reimbursement Issues; and
- Network Contracting.

Hours of Operation and Contact Telephone Numbers

Pharmacy Services for Passport Advantage	
24 hours, 7 days a week	(866) 533-5490

ARGUS HEALTH SYSTEMS

Argus Health Systems, Inc. processes claims for PAD members and continues to bring a tradition of excellence to point-of-sale (POS) claims processing.

Argus Processing Numbers/Plan Code Requirements

The following are mandatory Argus coding requirements for all PAD pharmacy POS claims:

BIN Number	Processor Control Number (PCN)
012353	03650000

***Note: Pharmacies must contact their switching network to update BIN's.**

Argus Health Systems provides technical assistance and support to pharmacies with host processing issues. If you have difficulty in transmitting claims for PAD members due to host processing or claim submission errors, please contact Argus Health Systems.

ARGUS Health Systems Help Desk:	
24 Hours a day, 7 days a week	(800) 913-3108

PAD PROVIDER/MEMBER SERVICES

If you experience an eligibility problem, please contact PAD Provider Services.

PAD Provider Services	
Monday – Friday 8:00 a.m. to 6:00 p.m. (EST) excluding weekends and holidays	(800) 578-0775

Please do not refer members to the PerformRx Help Desk.

PAD Member Services	
7 days a week 8 a.m. to 8 p.m.	(800) 578-0603, press 1 TTY: (888) 857-4816

MEMBER ELIGIBILITY

Individuals must be current Passport Health Plan members with Medicare Parts A and B to join.

Medicaid eligibility is determined by Kentucky Medicaid. PAD provides daily updates to the Argus system. It is important to remember that a member's eligibility could change on a month to month basis.

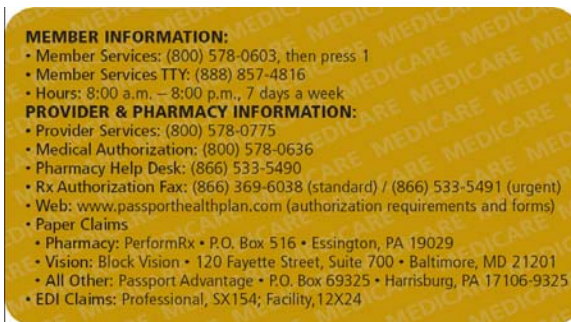
Pharmacies must verify the member's PAD ID card online through the Argus IPNS Point-Of-Services (POS) processing system or by calling PAD Provider services each time a member presents for services.

Member ID Card

Members should be asked to present their PAD member ID card at each visit.

Remember, possession of an ID card does not guarantee eligibility for benefits coverage or payment.

The following is a sample illustration of the PAD member ID card:



Member Date of Birth Edit

Pharmacists must enter the member's correct date of birth on each claim. If a claim is rejected due to an incorrect date of birth (Argus reject code 91), please contact the PerformRx Help Desk to verify the member's date of birth.

Member Copayments

All Passport Advantage members have a small LIS (low income subsidy) copayment for their prescription medications. Generally, Passport Advantage members will have a small copayment for their prescription medications. Also, they pay \$0 for other covered services/supplies (i.e. Part B drugs).

The pharmacy will be made aware of any copayment responsibility when the claim is adjudicated.

If the copayment is greater than expected, please call the PerformRx Help Desk for additional information and directions for correctly processing this claim request. If a PAD member thinks he/she is being overcharged, pharmacies must follow "Best Available Evidence" policies.

If you need assistance processing a temporary supply, coordination of benefit (COB), third party liability (TPL) or copay override claim, please contact the PerformRx Help Desk.

POINT OF SERVICE (POS) POLICIES

Processing Numbers/Argus Plan Code Requirements

The following are mandatory claim processing coding requirements for all pharmacy POS claims:

Argus BIN number: **012353**.

Processor control number: 03650000

The pharmacy must process all PAD member ID numbers as shown on the member's ID card. No prefix or suffix zeroes need to be added. A group number and a line number are not required for claim submissions and should not be submitted with a pharmacy claim.

Electronic Claims Submission

Pharmacies are required to submit PAD claims electronically to Argus Health Systems (see "Coordination of Benefits Procedure" section of this manual).

Claims Reversal

Pharmacies can reverse claims online up to 180 days from the original date of service. The pharmacy must conduct due diligence to ensure that prescription drug claims not received by the member are reversed within 30 days of the initial fill date. Claim reversals are indicated in cases where a prescription claim was adjudicated but never received by an eligible member. **All prescriptions not received by eligible members must be returned to stock within 30 days of processing and must be reversed.**

If the pharmacy is unable to completely process a reversal online, please call the PerformRx Help Desk for assistance.

If a PAD member is owed a partial amount of their prescribed, covered prescription, the pharmacy must modify the claim via the Argus online system within 14 days to accurately represent the quantity of medication received and billed. Pharmacies will be audited for claims reversals.

Paper Claim Submission

If a pharmacy attempts and is unable to submit a claim for reimbursement electronically through Argus, then the pharmacy may submit a paper universal claim form containing all the required NCPDP claims submission fields. Claims should be mailed to the following address:

**Passport Advantage
P. O. Box 486
Essington, PA 19029**

For assistance with claims submission, please contact the PerformRx HelpDesk.

Prescriber Identification Numbers

PerformRx, in accordance with the Centers for Medicare & Medicaid Services (CMS) regulations and guidance, requires all of its contracted pharmacies to process pharmacy prescription claims using the prescriber's National Provider Identifier (NPI).

If a member presents a prescription without the prescriber's NPI, please:

1. Call the prescriber's office to request the NPI; or
2. Obtain the prescriber's NPI from the NPI registry web page:
<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

NCPDP Field Requirements:

NCPDP Field	Value
Prescriber ID NCPDP Field 411-DB	Prescriber NPI
Prescriber ID Qualifier NCPDP field 466-EZ	01

- If a valid prescriber NPI is not used in the processing of a pharmacy claim, then the pharmacy will receive the reject code "invalid prescriber ID."

- Pharmacies substituting a pharmacy NPI as a prescriber NPI on pharmacy claims will not be accepted.

If you have any questions/concerns regarding claims submission using an NPI, please call the PerformRx Pharmacy Help Desk.

Product Service Codes/Dispense As Written (DAW) Codes

Argus supports the standard NCPDP dispense as written (DAW) product service codes. To ensure accurate reimbursement and avoid audit issues, always use the correct DAW codes when you submit a claim. The Argus POS claims processing system recognizes and accepts DAW codes 0, 1, 5, 7 and 8, as listed below.

DAW 0: No Dispense as Written (Substitution allowed)

DAW 1: Brand Requested By Physician Requires Prior Authorization

DAW 5: Brand Product Selected As Generic

(Pharmacy reimbursement will be at Plan maximum allowable cost)

DAW 7: Substitution not allowed (Drug mandated by law)

DAW 8: Product Not Available (May only be used when generic products are not available in the market place)

DAW code usage will be strictly monitored and audited for compliance.

Signature Logs

Pharmacy signature log records and/or electronic facsimile signatures are required to be kept on file in accordance with standard pharmacy practice, state and federal guidelines and laws. The signature log (includes delivered prescriptions) must be kept by the pharmacy for a period corresponding to the state pharmacy laws in which the pharmacy is located for retaining prescription hard copies. Signature log format should contain the following:

- Member name
- Prescription/medication reference number
- Date medications were picked up and/or delivered to a member
- Signature of the member or the member's representative

Signature logs and/or electronic facsimile signatures must be retrievable for in-store or desktop audits upon request or written notice. Pharmacies are not entitled to payment for any claim on the Third Party Signature Claim Log without the signature of the eligible member or authorized representative.

COORDINATION OF BENEFITS (COB) PROCEDURE

Commercial Insurance

Pharmacies must bill claims for Passport Advantage members with other primary insurance to the primary insurance first. The pharmacy then submits the copay portion to PerformRx electronically through the Argus POS System.

Argus Health Systems supports all online secondary billing NCPDP coverage codes 00-07 for NCPDP version 5.1 secondary claim submissions. The following are the NCPDP standard code sets for submitting secondary claims:

- ØØ=Not specified
- Ø1=No other coverage
- Ø2=Other coverage exists: payment collected
- Ø3=Other coverage exists: claim not covered
- Ø4=Other coverage exists: payment not collected
- Ø5=Managed care Plan denial
- Ø6=Other coverage denied: not participating provider
- Ø7=Other coverage exists: not in effect on DOS

COB Billing (As Secondary)

To submit a secondary copay amount, the claim must first be submitted and paid by the primary payer, and a portion of the claim cost must be the responsibility of the primary payer. The claim will fully adjudicate with the secondary payer and will pay the difference between what the primary insurance pays and up to what the secondary insurance would pay. Submit the secondary COB claim online by placing the applicable NCPDP standard code in the 'Eligibility Clarification' field. The "Other Payment" field should reflect what the primary payer paid on the claim.

For secondary billing, a claim is assumed to be payable by the primary payer. The claim fully adjudicates with the secondary payer's Plan benefits, but adds an additional step to subtract the primary payer's paid drug benefit amount from the secondary payer's payment amount. PerformRx will accept secondary billing for medications by the primary payer up to what the secondary Plan allows. The secondary Plan benefit design will dictate if the drug is a covered benefit or not.

If no payment is payable by the primary payer, PerformRx will adjudicate the claim as primary, subject to the secondary Plan benefit design which will dictate if the drug is a covered benefit or not.

PerformRx recommends network pharmacies contact their software vendor if experiencing difficulty with processing secondary claims.

To submit copays manually on a universal claim form, indicate "Other Coverage, Yes" on the upper right hand corner of the form. Mail the universal claim form to:

**Passport Advantage
P. O. Box 486
Essington, PA 19029**

The COB online process is monitored through the pharmacy audit process. It is important to keep the primary insurer's explanation of benefits (EOB) on file for auditing purposes. *Insufficient documentation of the EOB may result in an audit reversal of the claim.*

Medicare Part B

For Passport Advantage members, pharmacies can submit certain Medicare Part B medications online through Argus. In some cases, an ICD-9 code will be required to complete processing. Please follow the online messaging returned by Argus. For drugs with the potential to be covered under either Part B or Part D, additional information will be required to properly process the claim under the correct benefit. Pharmacies will need to contact the PerformRx Help Desk for assistance.

Medicare Part B copays should be billed to Passport Health Plan as an online COB medication claim through Argus; however, Medicare Part D copays **cannot** be billed to Passport Health Plan. Pharmacies will need to contact the PerformRx Help Desk with any needed assistance. Any ancillary charges (nursing services, etc...) should be submitted to Passport Advantage by calling **(800) 578-0775**.

COB/TPL Overrides

COB/TPL is a program to identify member's other primary insurance with pharmacy benefits. If the member states that he/she does not have primary coverage and the claim rejects in Argus with the message "**bill primary, resubmit copay, ovrde 502**" the pharmacy must resubmit the claim with a 502 override code in the prior authorization field.

Pharmacies experiencing problems with processing temporary supplies should contact the PerformRx Help Desk for assistance.

PHARMACY PAYMENT

Payment Cycle

Argus processes check payments twice per month. The cycles run from the 1st to the 15th and the 16th through the last day of the month. Checks are mailed within eight business days from the end of each cycle. Please contact PerformRx Network Administration at **(800) 555-5690** if additional information is needed.

Claims processed through the Argus "wrap around" network will be paid on a three-cycle per month basis. For additional information, contact Argus Health Systems at **(800) 522-7487**.

Pricing Information

Argus updates the PerformRx pricing file (including AWP's) weekly with updates from First Data Bank (FDB).

Paper Claims

PerformRx accepts paper claims when a pharmacy dispenses covered medications to PAD members.

However, paper claims for secondary billing, claim reversals, or retroactive member eligibility must be submitted within 180 days of the date of service.

SUMMARY OF PLAN BENEFITS

Passport Advantage Formulary

PAD utilizes a formulary which may be found in the Pharmacy section of the PAD web site (www.passportadvantage.org). Preferred drugs are listed by therapeutic class and are approved by the Passport Advantage Pharmacy and Therapeutics (P&T) committee. Special requirements for coverage may apply such as quantity limits, step therapy or prior authorization (coverage determination). All other drugs not listed on the formulary require prior authorization (coverage determination). The P&T committee considers all FDA approved drugs for inclusion on the formulary. When a new drug is reviewed for inclusion, an attempt will be made to examine the drug relative to similar drugs currently on the formulary.

All prescriptions must be filled at a participating pharmacy, unless a medical emergency or an out-of-area situation exists. Prescriptions that require **special** authorization procedures will have a response within 24 hours of the request.

Maximum Days Supply

PAD members are entitled to a maximum of a 30-day supply for retail pharmacies and 31 day for long-term care pharmacies. Medications may be presented for refill when 75% of the medication is utilized (for example a 30-day supply is renewable approximately five days before last day of medication).

The pharmacy must fill medications within the 30-day supply timeframe. Pharmacies may not automatically “Cycle Fill” medications.

Compounded Prescriptions

Compounds must be submitted with a compound indicator code ‘2’ along with the NDC number of the most expensive ingredient. PAD will not accept claims submitted with NDC numbers as all 9’s. Additional information and assistance for the processing of multi-ingredient compounds can be found at www.performrx.com/provider/index.aspx.

Please note: compounds require prior authorization. Please see the “Compound Payer Sheet” in the Appendix of this manual for more information.

Excluded Drugs

PAD does not cover drugs excluded from Medicare. These include Over-the-Counter (OTC) medications, benzodiazepines and barbiturates (see appendix for additional excluded drugs.)

However, PAD members may obtain certain OTCs, benzodiazepines and barbiturates under their Passport Health Plan (Medicaid) prescription drug benefit. Please refer to www.passporthealthplan.com for the OTC preferred drug list. If a PAD member presents a prescription for benzodiazepines, barbiturates or OTCs, please bill these prescriptions to Passport Health Plan (PHP). These OTC medications will require a prescription from the member's prescriber.

Note: Upon attempting to adjudicate a OTC claim for payment under PAD, the pharmacy will receive a message stating non-coverage, upon receiving this, the pharmacist is instructed to use the member's PHP card and information to submit the OTC to the PHP BIN and PCN number.

Early Refill of Prescriptions

Medications may be presented for refill when 75% of the medication is utilized (for example a 30-day supply is renewable approximately five days before last day of medication). If an eligible member requests an "early fill" too soon, inform the member of the Plan limitations and when the prescription can be refilled without a rejection.

Should the pharmacy encounter a "refill too soon" rejection on a medication for which the prescriber has made a dosage increase, the pharmacy now has the ability to enter an override code of **555555** in the prior authorization field and resubmit the claim. Argus will recalculate the days supply of the previous fill based on the new directions and either pay the claim (if 75% utilized) or return the new calculated refill due date (if not 75% utilized). This code only overrides the "refill too soon" error. If a medication was prior authorized, the pharmacy will need to contact PerformRx Pharmacy Provider Services for assistance.

If a medication must be replaced due to loss, theft or other damage, it is the pharmacist's responsibility to contact the PerformRx Help Desk and request the appropriate early refill authorization.

Vacation/Holiday Supplies of Medication

Early medication refills are allowed for the dispensing of vacation or holiday supplies. Each member is allowed up to two early refills per year for this purpose. The pharmacist must call the PerformRx Help Desk to obtain the appropriate vacation supply override authorization.

Transition Supply

Retail: Within the first 90 days of coverage, all new PAD members are eligible to receive a one-time transition supply of a medication that is either non-formulary, requires prior authorization, or step therapy. This fill is limited to a 30-day supply (unless prescription is written for fewer days). Rejection codes, in this instance, can be overridden by resubmitting the claim with "21000" in the prior authorization field. Each transition fill will generate an explanatory letter to the member with further instructions.

Long Term Care: Within the first 90 days of coverage, all new PAD members are eligible to receive transition fills of a medication that are either non-formulary, requires prior authorization, or step therapy. This fill is limited to a 31 day supply (unless the prescription is written for fewer days). New members are eligible for multiple refills as necessary for up to 90 days. Rejection codes, in this instance, can be overridden by resubmitting the claim with “41000” in the prior authorization field and. Each transition fill will generate an explanatory letter to the member with further instructions.

When a prescription claim is rejected online, pharmacies will receive one of the following messages:

- Drug excluded on Plan formulary
- Exceeds quantity therapy allowed
- NDC not on Plan’s preferred drug list
- Prior authorization not usable for this claim
- Prior authorization required
- Prior drug therapy required by Plan
- Use appropriate tab or cap strength for dose

Pharmacies experiencing problems with processing transition supplies should contact the PerformRx Help Desk for assistance.

Emergency Supply

Long Term Care:

After the initial 90-day transition coverage, all members are eligible for an annual 31-day emergency supply of a medication that is either non-formulary, requires prior authorization or step therapy. Rejection codes, in this instance, can be overridden by resubmitting the claim with “42000” in the Prior Authorization field. Each transition fill will generate an explanatory letter to the member with further instructions.

Change in Level of Care

Members who have a change in level of care (setting) will be allowed a one-time 31-day transition supply per drug. The prior authorization code will be “23000” and will be determined by the location code on the claim form.

If a member’s level of care changes due to a hospitalization, this change cannot be determined by location code on the claim form. Pharmacies may enter a reason for service in the NP (new patient) field on claim form. The claim will pay provided it is the first fill in a given month. Should the medication be non-formulary or require prior authorization, an explanatory letter will be sent to the member with further instructions. If the member has more than one change in level of care in a single month, the pharmacy must contact the PerformRx Help Desk at **(866) 533-5490**.

LONG TERM CARE (LTC)

To assure correct LTC reimbursement, LTC claims must be submitted with the patient location code of ‘3’ in the NCPDP Patient location field. Assisted Living Facility (ALC) claims must be submitted with the patient location code of ‘5’ in this field.

The following NCPDP codes may be used by LTC pharmacies, where applicable, in the NCPDP field # 420-DK:

REASON	CODE
Leave of absence (maximum of 7 days supply)	3
Lost medications (maximum of 3 days supply)	4
Therapy change	5

Please follow guidelines and override codes for transition and emergency supplies located in the “**Summary of Plan Benefits**” section of this manual.

LTC pharmacies have an extended 90-day submission and reversal limit on LTC claims.

SPECIALTY INJECTABLES

Coverage Procedure for all Part D High Cost Self-Injectable Medications

All high-cost injectable medications require prior authorization. The appropriate injectable request form should be completed with the necessary medical information and then faxed to the PerformRx Injectable Management Program at **(866) 369-6045**. The following includes, but is not limited to high-cost self-injectable medications requiring need prior authorization and submission of injectable request forms:

- Arixtra[®]
- Fragmin[®]
- Heparin
- Innohep[®]
- Leukine[®]
- Lovenox[®]
- Neulasta[®]
- Neupogen[®]

Questions related to specialty injectable products should be directed to the PerformRx Injectable Management Program.

Injectable Department Telephone Number	(866) 533-5490
Injectable Department Fax Lines	866-533-5498 Standard 866-546-7972 Urgent

- **Non-Urgent Injectable Requests** (*coverage determination can be made within 72 hours*)

- **Urgent Injectable Requests** (*seriously jeopardizes the member's life, health, or ability to regain maximum function and therefore requires a 24-hour coverage determination*)

For any questions regarding coverage of self-injectable medications, or to request an appropriate injectable order form, please contact the Perform Rx Injectable Management Program.

Coverage Procedure for all Medicare Part D Home Infusion Therapies

All Medicare Part D home infusion therapies require prior authorization and should be adjudicated through Argus for payment. Total Parenteral Nutrition (TPN) requests that are authorized for payment must be billed through Argus as a compound (see “Compound Prescriptions” Section of this manual).

A letter of Medical Necessity for the following Medicare Part D home infusion therapy requests must: be faxed to the PerformRx Injectable Management Program:

1. Intravenous Immune Globulin (IVIG) requests that do not meet Medicare Part B coverage guidelines:

Diagnosis(es) must include the following information; member weight, medical reason why recommended first line therapies cannot be used to treat the member’s condition, and a reason the IVIG therapy would not be covered under Medicare Part B.

2. Total Parenteral Nutrition (TPN) requests that do not meet Medicare Part B coverage guidelines:

Diagnosis(es) must include the following information: medical reason why member cannot receive nutrition by mouth or through tube feeding; goal of treatment; expected length of therapy; pre-treatment pre-albumin; pre-treatment albumin; pre-treatment body weight; goal body weight; a reason why the TPN therapy would not be covered under Medicare Part B; and, current (within 30 days of renewal request) pre-albumin and albumin level and current body weight (for renewal to continue treatment).

Non-urgent Home Infusion Requests - fax forms and letters of medical necessity to **866-533-5498**.

Urgent Home Infusion Requests (*Urgent is defined as a situation which seriously jeopardizes the member's life, health, or ability to regain maximum function and therefore requires a 24 hour coverage determination*)- fax forms and letters of medical necessity to **(866) 546-7972**.

If you have any questions regarding the prior authorization of home infusion therapies or to request a home infusion order form, please contact the PerformRx Injectable Management Program at **(866) 533-5490**.

COVERAGE DETERMINATION

When a pharmacy submits a claim for medications requiring coverage determination, the Argus claims processing system will reject the claim and return a non-coverage message, requiring a prior authorization.

If the claim rejection is for a non-preferred medication, the pharmacy should contact PerformRx for the preferred medications and offer these preferred medication alternatives to the prescriber. The prescriber has the option to either (1) change therapy and order a medication not requiring coverage determination, or (2) complete and submit a coverage determination request to PerformRx.

Only prescribing physicians, members, or their appointed representatives (including pharmacists) may request a coverage determination.

If you are appointed by a member to request a coverage determination you must submit the completed Authorization of Representative and Coverage Determination forms to PerformRx using the following fax numbers:

PerformRx Coverage Determination Department:	
Monday through Friday 8:30 a.m. - 9:00 p.m. (EST)	TELEPHONE: (800) 684-5502
Saturday - Sunday 8:30 a.m. - 5:00 p.m. (EST)	FAX: (866) 369-6038 (Standard) (866) 533-5491 (Urgent)

Pharmacy Coverage Determination Fax Lines:	
24 hours a day, 7 days a week	866-369-6038 Standard 866-533-5491 Urgent

Urgent Requests

The urgent fax line is closely monitored for appropriate use, and should be restricted to prior authorization requests that may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function if not received within 24 hours. PerformRx Clinical Pharmacists reserve the right to determine urgency. Please be sure to explain the reason for urgency.

Receiving a Response

PerformRx's system will automatically respond with a confirmation of receipt to the fax machine which sent the prior authorization request. Then, the information is entered into the PerformRx system, and PerformRx will review the requests using PAD's clinical criteria. Please note, coverage determination decisions are not faxed to the pharmacy unless the appointed representative was a pharmacist.

Prescribers/members will receive one of the following decision notifications:

- **APPROVALS:** If the information submitted in the coverage determination is complete and meets PAD's medical clinical criteria, the coverage determination will be approved within 72 hours for a standard request and within 24 hours for an urgent request. The member will be notified via letter, and the prescriber will receive a fax indicating the approval.
- **DENIALS:** If a coverage determination request does not meet clinical criteria or is incomplete, the request will be reviewed with the Medicare Part D Medical Director and may be denied. The member will be notified via letter, and the denial information is faxed and mailed to the prescriber.

A copy of the PAD Coverage Determination Form is provided in the "Appendix" section of this manual and is available on the Pharmacy section of PAD web site, www.passportadvantage.org.

MAIL ORDER

As a MAPD-SNP, PAD does not endorse the use of mail order for delivery of medications to its members.

However, PAD members may request that medications be supplied in this manner on a temporary basis only. In doing so, the pharmacy agrees to deliver the medications in a manner which is considered to be secure and reliable with transactional tracking to assure delivery. A member signature must be obtained to substantiate the member's receipt of the medication.

PHARMACY CREDENTIALING

Pharmacies participating with PAD are required to complete the PerformRx Pharmacy Provider Credentialing Sheet in order to assist PAD's Member Services in directing members to pharmacies specific to their needs. This also enables PerformRx to maintain a current pharmacy provider network listing.

Pharmacies are responsible for informing PerformRx Pharmacy Network Services of any changes in credentialing information and/or pharmacy certificates. Written updates should be **faxed** to PerformRx's Pharmacy Network Services at **(800) 684-5504**.

Pharmacy providers may obtain information about PerformRx Quality Initiative Programs by contacting PerformRx Network Administration Department at **800-555-5690**.

PHARMACY AUDITS

As recipients of Federal funding, pharmacies must cooperate with PerformRx auditors and promptly provide access to all information/documents deemed necessary by auditors - including prescription hard copies, patient signature logs, purchase invoices, and documentation including computer data (without limitation). PerformRx, CMS, or PAD authorized representatives may, upon reasonable notice, audit a pharmacy's records pertaining to a specific members' prescriptions and the provision of covered services. PharmDur is the auditing subcontractor for PerformRx. On-site and/or desktop audits are randomly conducted on a routine and annual basis.

PerformRx or PAD may notify a pharmacy of complaints received with respect to customer service, any irregular billing practice or procedure, overpayment, fraud or abuse, non-compliance with PerformRx policies and procedures, or any other problem that PerformRx may discover by audit or otherwise. The pharmacy shall cooperate with PerformRx to resolve all issues.

The criteria currently used in conducting retrospective on-site and/or desktop audits include, but are not limited to the following:

- Invalid prescriber I.D.
- Excessive quantities dispensed for days supply limitations
- Early refill
- Duplicate dispensing for school/work/leave of absence
- Drug billed is different than drug dispensed
- Possible prescription splitting
- Package billing errors
- Valid prescriptions
- DAW parameters
- Duplicate therapy/prescriptions
- Temporary supplies
- Diagnosis codes

Pharmacy records may be requested and reviewed by PerformRx, its subcontractors, CMS, or PAD.

Pharmacy Audits by PharmDUR

PharmDUR, our audit subcontractor, is one of the largest independent pharmacy audit firms in the nation. PharmDUR, Inc. will analyze PerformRx's various prescription drug claims, which includes the utilization of their proprietary system application, AudiTrack, an automated overview information verification program. AudiTrack uses PerformRx's paid pharmacy claims data specifically developed rule sets, to develop reports pertaining to potential issues for review. AudiTrack provides reports on patient utilization, physician prescribing patterns, and pharmacy dispensing patterns.

Audit Appeals Process

Pharmacies wishing to appeal the results of a finalized audit may do so in writing to the following address:

**AmeriHealth Mercy PerformRx
200 Stevens Drive, 1st Floor
Philadelphia, PA 19113
Attn: PerformRx Pharmacy Audit Services**

A pharmacy technician will contact the pharmacy to initiate the audit dispute process once all documentation is obtained from the audit company.

To ensure an impartial review, PerformRx independently reviews finalized pharmacy audit documentation. PerformRx will re-evaluate documents submitted by the pharmacy provider but rejected by the audit company post-audit. PerformRx may request copies of audit documents from both the audit organization and the pharmacy. Pharmacies are notified in writing of the outcome of their appeal.

Protected Health Information (PHI) Disclosure

In accordance with its Business Associate Agreement with its members, PerformRx/PAD follows the following procedure regarding the disclosure of protected health information.

PerformRx shall use and disclose PHI for the purpose of providing pharmacy benefit management services. PerformRx shall ensure that its directors, officers, employees, contractors and agents shall:

- (1) Not use or further disclose PHI other than as permitted or required by law.
- (2) Implement all appropriate and reasonable administrative, physical and technical safeguards to maintain the security, integrity and confidentiality of PHI and comply with the security standards by the effective date of the final HIPAA Security Regulations.
- (3) Report promptly to PAD any use or disclosure of PHI not provided for by this Agreement of which PerformRx becomes aware.
- (4) Require subcontractors or agents to whom PerformRx provides PHI to agree to the same restrictions and conditions that apply to PerformRx pursuant to this Agreement.
- (5) Transfer to PAD, upon request, information necessary to allow PAD to promptly respond to a request by an individual for an accounting of the disclosures of the individual's PHI or for a copy of the individual's PHI.
- (6) Make PHI available for amendment or correction, and incorporate any amendments or corrections to PHI when notified by PAD that information is incomplete or inaccurate.
- (7) Maintain record keeping of all disclosures of PHI, other than for the purpose set forth in this Agreement, including the date, name of recipient, description of PHI disclosed and purpose of disclosure.

- (8) Make PerformRx internal practices, books, and records relating to the use and disclosure of PHI available to the Department of Health and Human Services for purposes of determining PAD's compliance with the HIPAA regulations.
- (9) At termination of the Agreement, return or destroy all PHI received from or on behalf of PAD that PerformRx still maintains in any form and retain no copies of such PHI; provided that if such return or destruction is not feasible, extend the protections of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- (10) PerformRx may use or disclose the PHI for the proper management and administration of PerformRx or to carry out its legal responsibilities, if (A) the disclosure is required by law; or (B) (1) PerformRx obtains reasonable assurance from the third party that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (2) the third party notifies PerformRx of any instances of which it is aware in which the confidentiality of the information has been breached.
- (11) PerformRx may de-identify PHI, provided that the de-identification conforms to the requirements of HIPAA. De-identified information is not PHI and is not subject to the terms of this Agreement.
- (12) PerformRx uses and discloses PAD member's PHI for purposes of treatment, payment and health care operations.
- (13) PerformRx verifies the identity and authority of an individual or agency seeking access to (or a disclosure of) PHI.
- (14) PerformRx does not use or disclose a PAD member's PHI without the member's written valid authorization, except for purposes of treatment, payment and health care operations or as otherwise required or permitted by law.
- (15) Unless otherwise directed by PAD, PerformRx will restrict uses and disclosures of PHI or confidential communications only at the direction of PAD, in the manner specified by PAD.
- (16) Unless otherwise directed by PAD, PerformRx will transfer to PAD, upon request, information necessary to allow PAD to timely respond to a request by an individual for an accounting of the disclosures of the individual's PHI.
- (17) When requested by PAD, PerformRx promptly responds to PAD members' complaints with respect to implementation of, or compliance with, the HIPAA privacy regulations in administration of the pharmacy benefit for PAD.

PerformRx is in compliance with the HIPAA regulations "Administrative Requirements for Transactions," 45 C.F.R. § 162.100 et seq., effective October 16, 2003.

Utilization Management Statement

PerformRx pharmacy drug utilization program is coordinated with PAD quality assurance programs to achieve quality care through a disease management approach. The Drug Utilization Program is designed to identify and correct potentially harmful prescribing patterns, enhance community-prescribing standards, and detect patterns of fraud and abuse. The policy and procedures meet Federal Statute/Regulation Citation Section 4401 (g) of OBRA '90 and 42 CFR 456, as well as NCQA guidelines.

FRAUD, WASTE, AND ABUSE

Office of Inspector General (OIG) Report

To read more about OIG activities to identify fraud and abuse involving HHS programs, go to: http://oig.hhs.gov/publications/docs/semiannual/2008/semiannual_spring2008.pdf.

FRAUD is understood to mean a dishonest and deliberate course of action that results in the obtaining of money, property or an advantage to which the recipient would not normally be entitled.

WASTE entails the expenditure or allocation of resources, treatment or in this context, Pharmaceuticals significantly in excess of need.

ABUSE defined here as a subset of waste, entails the exploitations of “loopholes” to the limits of the law, primarily for financial gain.

A pharmacist is required to exercise sound professional judgment with respect to the legitimacy of prescriptions orders dispensed. The law does not require a pharmacist to dispense a prescription order of doubtful origin. To the contrary, the pharmacist who deliberately turns the other way when there is every reason to believe that the purported prescription order had not been issued for a legitimate medical purpose may be prosecuted, along with the issuing physician, for knowingly and intentionally distributing controlled substances.

Examples of Fraud, Waste, and Abuse

The following section describes examples of pharmacy fraud, waste and abuse. Examples of potential fraud, waste and abuse include but are not limited to:

- Inappropriate billing practices: Inappropriate billing practices at the pharmacy level occur when pharmacies engage in the following types of billing practices:
- Incorrectly billing for secondary payers to receive increased reimbursement.
- Billing for non-existent prescriptions.
- Billing multiple payers for the same prescriptions, except as required for coordination of benefit transactions.
- Billing for brand when generics are dispensed.
- Billing for non-covered prescriptions as covered items.
- Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up).
- Billing based on “gang visits,” e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients.
- Inappropriate uses of dispense as written (“DAW”) codes.
- Prescription splitting to receive additional dispensing fees.
- Drug diversion.
- Prescription drug shorting: Pharmacist provides less than the prescribed quantity and intentionally does not inform the patient or make arrangements to provide the balance but bills for the fully-prescribed amount.
- Bait and switch pricing: Bait and switch pricing occurs when a beneficiary is led to believe that a drug will cost one price, but at the point of sale the beneficiary is charged a higher amount.
- Prescription forging or altering: Where an individual without the prescriber’s permission to increase quantity or number of refills alters existing prescriptions.

- Dispensing expired or adulterated prescription drugs: Pharmacies dispense drugs that are expired, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors: A pharmacist provides the incorrect number of refills prescribed by the provider.
- Illegal remuneration schemes: Pharmacy is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the pharmacy to switch patients to different drugs, influence prescribers to prescribe different drugs, or steer patients to Plans.
- TrOOP manipulation: When a pharmacy manipulates TrOOP to either push a beneficiary through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible, or manipulates TrOOP to keep a beneficiary in the coverage gap so that catastrophic coverage is never realized.
- Failure to offer negotiated prices: Occurs when a pharmacy does not offer a beneficiary the negotiated price of a Part D drug.

Prescriber Fraud, Waste and Abuse

The following section describes examples of prescriber fraud, waste and abuse. Examples of potential fraud, waste and abuse include but are not limited to:

- Illegal remuneration schemes: Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.
- Prescription drug switching: Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.
- Script mills: Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- Provision of false information: Prescriber falsifies information (not consistent with medical record) submitted through a Coverage Determination or other formulary oversight mechanism in order to justify coverage. Prescriber misrepresents the dates, descriptions of prescriptions or other services furnished, or the identity of the individual who furnished the services.
- Theft of prescriber's DEA number or prescription pad: Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market. In the context of e prescribing, includes the theft of the provider's authentication (log in) information.

Wholesaler Fraud, Waste and Abuse

The following section describes examples of wholesaler fraud, waste and abuse. Examples of potential fraud, waste and abuse include but are not limited to:

- Counterfeit and adulterated drugs through black and grey market purchases: This includes but is not limited to fake, diluted, expired, and illegally imported drugs.
- Diverters: Brokers who illegally gain control of discounted medicines intended for places such as nursing homes, hospices and AIDS clinics. Diverters take the discounted drugs, mark up the prices, and rapidly move them to small wholesalers. In some case the pharmaceuticals may be marked up six times before being sold to the consumer.
- Inappropriate documentation of pricing information: Submitting false or inaccurate pricing or rebate information to or that any Federal health care program may use.

Medicare Beneficiary Fraud, Waste and Abuse Risks

Typically, Medicare beneficiaries tend to be victims, not perpetrators, of fraudulent, wasteful or abusive schemes. However, there are some schemes committed by beneficiaries that may impact payers. The following section describes examples of the types of fraud, waste or abuse that could be perpetrated by beneficiaries in Part D, as well as examples where beneficiaries might be victimized. Examples of potential fraud, waste and abuse include but are not limited to:

- Misrepresentation of status: A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive the drug benefit. Members who are no longer covered under a drug benefit Plan may still attempt to use their identity card to obtain prescriptions.
- Identity theft: Perpetrator uses another person's Medicare card to obtain prescriptions.
- TrOOP manipulation: A beneficiary manipulates TrOOP to push through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible.
- Prescription forging or altering: Where prescriptions are altered, by someone other than the prescriber or pharmacist with prescriber approval, to increase quantity or number of refills.
- Prescription diversion and inappropriate use: Beneficiaries obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a beneficiary's medications by a caregiver or anyone else.
- Resale of drugs on black market: Beneficiary falsely reports loss or theft of drugs or feign illness to obtain drugs for resale on the black market.
- Prescription stockpiling: Beneficiary attempts to "game" their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market.
- Doctor shopping: Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.
- Improper Coordination of Benefits: Improper coordination of benefits where beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to "game" the system.
- Marketing Schemes: A beneficiary may be victimized by a marketing scheme where a Sponsor, or its agents or brokers, violates the Medicare Marketing Guidelines, or other applicable Federal or state laws, rules, and regulations to improperly enroll the beneficiary in a Part D Plan.

Excerpted from: Centers for Medicare and Medicaid Services Prescription Drug Benefit Manual.
For more information, go to:

http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf

How to Report Suspected Fraud or Abuse

To report suspected fraud or abuse, contact either:

PerformRx Help Desk
Telephone: **866-533-5490**

or

Medicare Customer Service Center
Telephone: **800-633-4227**

To find additional information about Fraud, Waste, and Abuse, go to
<http://www.cms.hhs.gov/FraudAbuseforProfs/> on the CMS website.

APPENDIX I: Passport Advantage Excluded Medications

Drugs that are “excluded,” mean they are not normally covered by a Medicare drug plan. Passport Advantage does not normally cover Medicare-excluded drugs unless they are found upon appeal to be drugs that Passport Advantage should have paid for or covered.

Passport Health Plan may provide Medicaid coverage for certain drugs excluded from Medicare. Please call Passport Advantage Help Desk if you have any questions.

- A Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan cannot cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug’s label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If one of these reference books, known as compendia, does not support the use then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain (unless specific to weight loss due to HIV). (Please note these may be covered by your Passport Health Plan Medicaid benefits.)
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth. (Please note vitamin analogs used for dialyses and Niacin prescription products used for a diagnosis of hyperlipidemia may be covered benefits.)
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines. (Please note these may be covered by your Passport Health Plan Medicaid benefits.)
Drugs used for the treatment of sexual or erectile dysfunction such as Viagra, Cialis, Levitra, and Caverject.	

APPENDIX II. Provider Coverage Determination Form



Medicare Part D Coverage Determination Request Form

Prior Authorization Department
200 Stevens Drive
Philadelphia, PA 19113
1-800-684-5502
FAX Standard: 1-866-369-6038
FAX Urgent: 1-866-533-5491

This form cannot be used to request:

- ▶ Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- ▶ Biotech or other specialty drugs for which drug-specific forms are required. [See www.performrx.com]

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID#			NPI# (if available):		
Address:			Address:		
City:	State:		City:	State:	
Home Phone:	Zip:		Office Phone:	Office Fax:	Zip:
Sex (circle):	M	F	DOB:	Contact Person:	
Diagnosis and Medical Information					
Medication:		Strength and Route of Administration:		Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:		Qty:	
Height/Weight:	Drug Allergies:		Diagnosis:		
Prescriber's Signature:				Date:	
Rationale for Exception Request or Prior Authorization FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION					
<input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure). → Specify below: (1) drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)					
<input type="checkbox"/> Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk for significant adverse clinical outcome with medication change. → Specify below: Anticipated adverse outcome					
<input type="checkbox"/> Medical need for different dosage form and/or higher dosage. → Specify below: (1) dosage form(s) and/or dosage(s) tried; (2) explain medical reason					
<input type="checkbox"/> Request for formulary tier exception. → Specify below: (1) Formulary or preferred drugs contraindicated, tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and anticipated benefit of requested drug					
<input type="checkbox"/> Other: _____ → Explain Below					
EXPLANATION REQUIRED: _____					
EXPLANATION REQUIRED: _____					
EXPLANATION REQUIRED: _____					
Request for Expedited Review					
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] → BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.					

Pharmacy benefit provided by PerformRx, the next generation PBM
Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

H1807-001 PAD 170 12/06

APPENDIX III. Argus Interpretation Tool

Rejection Reasons	Denial Code Investigations Error Codes	
1. Pharmacy receives a rejection “medication not covered or PA (Coverage Determination) required”.	96-PA Required 164—below pediatric maximum dosage guidelines 177-Use appropriate tab or cap for dose 9-Unit dose items are excluded under this Plan	1. Pharmacy will need to call the PerformRx Help Desk to determine if medication is a continuation of therapy new therapy, or if change in tab/cap dispensed required. If this is a continuation PerformRx Pharmacy Services will update PA. If this is new therapy, will need a PA
2. Pharmacy receives a rejection that the NDC (National Drug Code) number is not on file.	16 NDC is not on file.	2. Pharmacy needs to call PAD Provider Services for assistance.
3. Pharmacy receives a rejection that the member is not eligible.	2- Member not eligible on date of fill	3. The Pharmacy will need to call PAD Provider Services for verification or check DUR.
4. Pharmacy receives a rejection that member has other insurance.	90-Submit to primary payor	4. Pharmacy will need to put in a 502-override code and advise the member to call PAD Member Services to have the other insurance corrected.
5. Pharmacy receives a rejection that the Physician’s License is not valid.	34-Prescriber ID invalid or 65-Prescriber not eligible on date filled	5. Pharmacy needs to verify that the provider NPI number is correct on the claim. The default DEA number is not useable for controlled medications; a valid DEA number must be used in these transmissions. Providers should contact the PerformRx Help Desk for assistance.
6. Pharmacy receives a rejection that the member’s medication denies for: Duplicate Therapy, Drug Preferences or Therapy Protocols.	47-This therapy may duplicate current therapy	6. Pharmacy needs to call PerformRx the Help Desk for assistance.
7. Pharmacy has a problem with a script going through the system.		7. Pharmacy will need to call the PerformRx Help Desk.
8. Pharmacy receives a “refill too soon” rejection. (Increase in dosage).	80- Refill too soon	8. Pharmacy will use the 555555 in the prior auth field if this is an increase in dosage. (Note: ARGUS will recalculate the days supply of the previous fill based on the new directions and either pay the claim if 75% utilized or return the new calculated refill due date) If medication was prior authorized, the pharmacy will need to contact the PerformRx Help Desk.
9. Pharmacy receives rejection “product service not covered”.	21-NDC not covered-generic required 43-This NDC is not on preferred drug list 48-NDC not covered-non-formulary drug 158-NDC not covered w/o appropriate diagnosis code	9. Pharmacy needs to call the PerformRx Help Desk for assistance.
10. Pharmacy receives rejection for “Plan limits exceeded”.	51-Quantity less than minimum for this Plan 29-Quantity greater than allowed by this Plan 151-Exceeds quantity therapy allowed 145-Exceeds therapy allowed at dose 76-Plan limitations 62-Claim denied-over annual	10. Pharmacy needs to call the PerformRx Help Desk for assistance.
11. Pharmacy receives a rejection for an obsolete drug.	108-Desi drugs are excluded under this Plan 136-OTC drugs are excluded under this Plan	11. Pharmacy needs to call the PerformRx Help Desk for assistance.

**Form Instructions
“Medicare Prescription Drug Coverage and Your Rights”
Pharmacy Notice
CMS-10147**

A Medicare Part D plan must provide this notice to its network pharmacies for use in instructing enrollees to contact their Part D plan (Medicare drug plan) to obtain a coverage determination, including a formulary or tiering exception, if the enrollee disagrees with the information provided by the pharmacist. This notice may be distributed to enrollees or conspicuously posted at the pharmacy. Posted notices must be large enough to be easily read by the target audience. This notice fulfills the requirements at 42 CFR §423.562(a)(3).

This is a standard notice. Part D plans may not deviate from the content of this notice. Please note that the OMB control number must be displayed in the upper right corner of the notice.

Heading

Logo not required. Pharmacies may elect to place their logo in the space above “Medicare Prescription Drug Coverage and Your Rights.”

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to complete this information collection is estimated to average one minute per response, including the time to select the preprinted form and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

No. CMS-10147

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

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

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

You **also have the right to ask** your Medicare drug plan **for an exception** (a special type of coverage determination) **and get a written explanation** from your Medicare drug plan if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- You believe a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a coverage determination, including an exception request.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:
 1. The prescription drug(s) that you believe you need. Include the dose and strength, if known.
 2. The name of the pharmacy or prescriber who told you that the prescription drug(s) is not covered.
 3. The date you were told that the prescription drug(s) is not covered.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to complete this information collection is estimated to average one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NOTES:

